

Appendix A

1 UNITED STATES DISTRICT COURT

2 SOUTHERN DISTRICT OF NEW YORK

3 _____)
4 ASTRAZENECA AB, AKTIEBOLAGET)
HASSLE, KBI-E INC., KBI INC.,)
5 and ASTRAZENECA, LP,)
6 Plaintiffs,)
7 vs.) Civil Action No.
8 APOTEX CORP., APOTEX, INC. and) 01-CIV-9351 (DLC)
TORPHARM, INC.,)
9 Defendant.)
10 _____)
11 In re OMEPRAZOLE PATENT LITIGATION) Civil Action No.
12 _____) M-21-81 (DLC)
MDL Docket
No. 1291

13
14 VIDEOTAPED DEPOSITION OF EXPERT

15 GORDON C. RAUSSER, Ph.D.

16 Emeryville, California

17 Friday, August 9, 2013

18 Volume I

19
20 CONFIDENTIAL - PURSUANT TO COURT ORDER

21
22 Reported by:
ANA M. DUB, RPR, RMR, CRR, CCRR, CLR
23 CSR No. 7445

24 Job No. 15216

25 (Pages 1 - 220)

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 14..17

<p>Page 14</p> <p>1 A. No.</p> <p>2 Q. Did you speak with any AstraZeneca</p> <p>3 employees while preparing your report or preparing</p> <p>4 to be deposed?</p> <p>5 A. No, with regard to being deposed. Yes,</p> <p>6 with regard to speaking to other officers of</p> <p>7 AstraZeneca in the prior engagement.</p> <p>8 Q. What -- so, I'm sorry. Let me rephrase</p> <p>9 that.</p> <p>10 You say that you spoke with AstraZeneca</p> <p>11 employees while preparing your previous</p> <p>12 declarations. What topics did you discuss with</p> <p>13 them?</p> <p>14 A. Their -- largely, much of the discussion</p> <p>15 went to some of the documents produced in the normal</p> <p>16 course of business, the interpretation of those</p> <p>17 documents. There was also general discussion in a</p> <p>18 meeting involving a number of AstraZeneca people on</p> <p>19 their rebating strategies with regard to managed</p> <p>20 care.</p> <p>21 Q. And do you remember who you spoke with?</p> <p>22 A. No.</p> <p>23 Q. Did you review any internal AstraZeneca</p> <p>24 documents while preparing these declarations? When</p> <p>25 I say "these," I mean in this -- in the instant</p>	<p>Page 15</p> <p>1 case.</p> <p>2 A. Whoops. I'm sorry. It's -- your question</p> <p>3 is difficult to sort out. I mean, I've reviewed a</p> <p>4 lot of documents. And you said "in preparing."</p> <p>5 I've reviewed them either before and/or after</p> <p>6 preparing the actual declarations.</p> <p>7 (Mr. Quies leaves the proceedings.)</p> <p>8 THE WITNESS: Thank you. Thank you.</p> <p>9 Jenny should be the responsible person. She cleans</p> <p>10 up all my messes.</p> <p>11 MR. ANDERSON: It's good to have those</p> <p>12 people around.</p> <p>13 MS. KINBURN: Speaking of your</p> <p>14 declarations . . .</p> <p>15 (Mr. Quies joins the proceedings.)</p> <p>16 THE WITNESS: Thank you very much.</p> <p>17 MS. KINBURN: They are, of course,</p> <p>18 voluminous. I'd like to mark -- this will be</p> <p>19 Exhibit 1.</p> <p>20 (Whereupon, Deposition Exhibit 1 was</p> <p>21 marked for identification.)</p> <p>22 MS. KINBURN: And then Dr. Rausser's</p> <p>23 supplemental declaration will be Exhibit 2, for</p> <p>24 completeness's sake.</p> <p>25</p>
<p>Page 16</p> <p>1 (Whereupon, Deposition Exhibit 2 was</p> <p>2 marked for identification.)</p> <p>3 BY MS. KINBURN:</p> <p>4 Q. Dr. Rausser, does that appear to be your</p> <p>5 declaration in this matter?</p> <p>6 A. Yes.</p> <p>7 Q. If you could please take a look at the</p> <p>8 last page of your declaration, this is Exhibit C,</p> <p>9 "Materials Reviewed and Relied On."</p> <p>10 A. Yes.</p> <p>11 Q. Do you see any internal AstraZeneca</p> <p>12 documents, or can you point them out to me, that you</p> <p>13 relied on in preparing your declaration?</p> <p>14 A. Certainly. The AstraZeneca rebate data</p> <p>15 for both Nexium and Prilosec are all internal</p> <p>16 AstraZeneca documents.</p> <p>17 In addition to those documents, others</p> <p>18 that I have reviewed and evaluated are documents</p> <p>19 that have been produced by the defendant experts.</p> <p>20 And along with that, I think I cited at the</p> <p>21 beginning of my declaration my prior report and all</p> <p>22 the documents that I relied upon in my prior report,</p> <p>23 which has been produced to you, as I understand it.</p> <p>24 Q. So you rely not only on the documents</p> <p>25 cited in your Exhibit C here, but anything cited in</p>	<p>Page 17</p> <p>1 your previous declaration?</p> <p>2 A. Yes.</p> <p>3 Q. Can you tell me what academic experience</p> <p>4 you have with regard to the pharmaceutical industry?</p> <p>5 A. Certainly. Academic experience or just</p> <p>6 experience?</p> <p>7 Q. Let's start --</p> <p>8 A. You're making a --</p> <p>9 Q. -- academic.</p> <p>10 A. You're making a separation between the</p> <p>11 two?</p> <p>12 Q. If possible.</p> <p>13 A. Certainly. While on the faculty of</p> <p>14 Harvard University, I orchestrated a major case on</p> <p>15 the pharmaceutical industry. And there was a</p> <p>16 complete evaluation of market dynamics, looking at</p> <p>17 the effect of entry, patent expiration, and the</p> <p>18 pricing and marketing and promotion strategies.</p> <p>19 This was done as a case study, and it</p> <p>20 subsequently became a case that was taught in a</p> <p>21 second-year M.B.A. course that looked at competition</p> <p>22 in markets and strategies used by various companies,</p> <p>23 particularly in markets that were not characterized</p> <p>24 as perfectly competitive markets.</p> <p>25 Subsequently, I have done work on --</p>

Page 18

1 academic work on patents and specifically looked at
2 questions related to R&D, search, and the effect of
3 those kinds of actions on discovery and whether, in
4 fact, the discoveries result in codified
5 intellectual property that has some inherent value.
6 And then along the way there's been
7 various Ph.D. students who I've provided
8 mentorship -- mentorship, responsibility as the
9 chairman on their dissertation committees, in which
10 they've looked at various questions that relate,
11 once again, to market structure, pricing dynamics,
12 strategies that companies sometimes use under the
13 Hatch-Waxman rules of entry and patent expiration.
14 Q. Okay. Can you tell me what other
15 experience you have in the pharmaceutical industry?
16 A. Now we're beyond academic experience?
17 Q. Yes.
18 A. Yes. Over the course of the last 20-plus
19 years, beginning in, I guess, 1992 when I was
20 engaged as the joint defense expert, this was a case
21 that went on for 12 years. Well, the original case
22 was a class case, but then there were subsequent
23 opt-out plaintiffs that I was an economic expert
24 evaluating damages.
25 Q. And which case was that?

Page 20

1 engaged as a consultant, helping with regard to the
2 launch of some new products with regard to pricing,
3 marketing and promotion.
4 Q. Okay. To go back to what I was going to
5 ask, when you were . . .
6 I'm sorry. You said that you, on a few
7 negotiations, witnessed and observed negotiations
8 between managed care and/or PBMs. Can you define
9 "managed care and/or PBMs"?
10 A. Certainly, I think Mr. Navarro has already
11 done that for you in this litigation. He has
12 provided a complete description of the institutional
13 structure.
14 And what PBMs, pharmacy benefit managers,
15 they actually serve a role as agents for a
16 third-party payer with regard to managing the
17 trade-off between cost and efficacy of different
18 therapies that are available on the marketplace for
19 their responsible covered lives.
20 Managed care generally refers to that
21 channel in which there is active involvement with
22 regard to designing formularies, using formularies
23 to manage both the cost and the prescriptions that
24 are written by physicians; sometimes simply
25 influencing them, in other cases controlling what

Page 19

1 A. The branded -- Brand Name Antitrust
2 Litigation.
3 In that particular case, I got access to
4 all the proprietary data of the defendants and also
5 was completely educated with respect to the managed
6 care channel and pharmaceutical manufacturers'
7 strategy with regard to moving volume, trying to
8 create incentives for moving more volume through the
9 market.
10 Actually went, on a few occasions, to
11 witness and observe the actual negotiations between
12 some managed care and/or PBMs with regard to setting
13 the conditions with regard to different levels of
14 rebates, depending on the volume that was moved by
15 that specific entity.
16 Q. Why don't I stop you there just so --
17 A. No. I want to complete my response. You
18 asked me the question. Let me complete the response
19 to the question.
20 Following that particular work, I've been
21 engaged on at least 40 times, maybe as many as 50
22 times, to evaluate patent infringement, patent
23 validity, commercial success, FDA approval. I've
24 helped in a couple of instances with respect to the
25 design of clinical trials. And I've also been

Page 21

1 physicians actually write with regard to
2 prescriptions.
3 Q. So those negotiations, were they between
4 managed care and PBMs or were they between those two
5 entities and brand-name drug manufacturers?
6 A. The latter.
7 Q. So you mentioned that that related to --
8 that those negotiations related to formulary status
9 in some extent.
10 What other experience do you have with
11 regard to formularies in the pharmaceutical
12 industry?
13 A. I've certainly reviewed formularies. I've
14 reviewed the standard scorekeeper with respect to
15 data that is available on formulary status and how
16 those formularies change with regard to maybe its
17 inherent structure but, also, where a brand drug
18 versus a generic drug sits on the formularies, what
19 the co-pays are for different tiers, whether -- I've
20 also seen the actual contracts.
21 I've reviewed P&T committees with regard
22 to their assessment of the efficacy of various
23 therapies and whether a particular therapy, its
24 incremental effectiveness is justified by whatever
25 cost of that therapy. I have on a couple of

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 54..57

<p>Page 54</p> <p>1 Q. Just to clarify, this</p> <p>2 cross-pricing elas- -- cross-price elas- --</p> <p>3 A. Elasticity.</p> <p>4 Q. Elasticity. Thank you.</p> <p>5 Is the substitutability that you're</p> <p>6 speaking of the substitution that a doctor might</p> <p>7 prescribe, that a patient would ask for, or that a</p> <p>8 third-party payer would consider? I'm just not sure</p> <p>9 where the substitution that you're speaking of comes</p> <p>10 into play.</p> <p>11 A. All of those factors play a role in the</p> <p>12 degree of substitutability.</p> <p>13 With regard to the third-party payer, what</p> <p>14 influence or control do they have on prescribing</p> <p>15 physicians' behavior? That's certainly an important</p> <p>16 part of determining the degree of substitutability,</p> <p>17 and formularies play a role in that respect.</p> <p>18 If a formulary has some incentives by</p> <p>19 putting one of the PPIs at a more favorable tier</p> <p>20 with a lower co-pay, that's certainly going to</p> <p>21 affect the substitutability among the PPIs.</p> <p>22 The prescribing doctors certainly have</p> <p>23 some influence over the degree of substitutability.</p> <p>24 And ultimately, the patients do as well because if</p> <p>25 there's a particular therapy among the PPIs that</p>	<p>Page 55</p> <p>1 works very well, it's very likely that they're going</p> <p>2 to be sticky and continue to use that particular</p> <p>3 therapy.</p> <p>4 As I indicated with the positioning of</p> <p>5 AstraZeneca with regard to Prilosec and the OTC</p> <p>6 version of that, that's an instance where they're</p> <p>7 trying to actually assist the consuming population</p> <p>8 with regard to the substitutability.</p> <p>9 All of those factors play a role.</p> <p>10 Q. How does that play into a third-party</p> <p>11 payer's decisions with regard to formulary status?</p> <p>12 A. Formulary status, as I indicated earlier</p> <p>13 today, if you look at the actual economic interest</p> <p>14 of the third-party payer, it is to balance the</p> <p>15 trade-off between cost and efficacy. So cost, in</p> <p>16 turn, is going to be influenced by the rebates that</p> <p>17 are offered by the manufacturer.</p> <p>18 And if it turns out based on their P&T</p> <p>19 committees or their assessment, the incremental</p> <p>20 efficacy, say, of Nexium vis-a-vis Prilosec, that</p> <p>21 may give them a favorable perspective on where</p> <p>22 Nexium should be placed on the formulary. But</p> <p>23 that's only one dimension that they look at.</p> <p>24 The other dimension is: What is the cost?</p> <p>25 That cost can be directly influenced by the amount</p>
<p>Page 56</p> <p>1 of rebates that are offered by AstraZeneca.</p> <p>2 Q. A third-party payer who's making decisions</p> <p>3 about their formulary with regard to PPIs would look</p> <p>4 at the efficacy of the various brands or generics?</p> <p>5 A. Mm-hmm.</p> <p>6 Q. And then the cost to them, presumably</p> <p>7 after rebates; is that correct?</p> <p>8 A. That is correct.</p> <p>9 MS. KINBURN: I'm going to mark as</p> <p>10 Exhibit 5 -- thank you -- Exhibit 6 AZD 166749.</p> <p>11 (Whereupon, Deposition Exhibit 6 was</p> <p>12 marked for identification.)</p> <p>13 BY MS. KINBURN:</p> <p>14 Q. Dr. Rausser, have you seen this document</p> <p>15 before?</p> <p>16 A. Yes.</p> <p>17 Q. And just for the record, this is a Nexium</p> <p>18 SCO brainstorming meeting from August 3rd, 2004.</p> <p>19 A. Yes.</p> <p>20 Q. If you could take a look at page 11, this</p> <p>21 is a slide that is headed "The PPI market is</p> <p>22 extremely price competitive." And it's a chart</p> <p>23 setting forward the current WAC with deepest rebate</p> <p>24 in HMO/PBM segment for various PPIs; is that</p> <p>25 correct?</p>	<p>Page 57</p> <p>1 A. Yes.</p> <p>2 Q. And when you look at this chart, do you</p> <p>3 notice that it has, as described in the title, two</p> <p>4 prices for each of these PPIs?</p> <p>5 The current WAC, which is the weighted</p> <p>6 average cost; is that correct?</p> <p>7 A. Yes, that's the title.</p> <p>8 Q. Okay. So it shows the current WAC and</p> <p>9 then also the deepest rebate that each of these PPIs</p> <p>10 is offering in the HMO/PBM segment.</p> <p>11 So would -- when you review this chart,</p> <p>12 does this comport with your understanding of the</p> <p>13 market for PPIs?</p> <p>14 MR. ANDERSON: You're talking about as of</p> <p>15 the date of this chart?</p> <p>16 MS. KINBURN: Yes.</p> <p>17 THE WITNESS: No. It's very imprecise and</p> <p>18 very misleading.</p> <p>19 BY MS. KINBURN:</p> <p>20 Q. Okay. Please explain how it's imprecise</p> <p>21 and misleading.</p> <p>22 A. First of all, look at omeprazole. First</p> <p>23 of all, it's not for the entire market. That's only</p> <p>24 for mail order. There are no rebates that I've been</p> <p>25 able to discover, as I point out in my report, as --</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 58..61

<p style="text-align: right;">Page 58</p> <p>1 in which there is any rebates offered, aside from 2 mail order, for omeprazole. So this is a very 3 misleading chart in that respect. That's the first 4 response. 5 The second response, "deepest," that means 6 nothing. It means nothing whatsoever. If there is 7 one instance, one transaction where a particular 8 rebate is offered to mail order with regard to a PPM 9 and it's one instance in which they're attempting to 10 move some additional volume, excess inventory or 11 whatever, is it systematic? That's the fundamental 12 question. None of these deepest rebates represent 13 market conditions. 14 So my answer to your question, this is a 15 very misleading chart that has no foundation for any 16 inferences. 17 MS. KINBURN: I'm going to mark as 18 Exhibit 7 a document marked AZD 185338. 19 (Whereupon, Deposition Exhibit 7 was 20 marked for identification.) 21 THE WITNESS: Is there a question? 22 BY MS. KINBURN: 23 Q. Yes. So just to identify the document, 24 this is a primary care - GI third quarter 2003 25 performance review dated October 3rd, 2003. Is that</p>	<p style="text-align: right;">Page 59</p> <p>1 correct? 2 A. It is. 3 Q. And this is an AstraZeneca internal 4 document? 5 A. Yes, it is. 6 Q. So this reflects information that 7 AstraZeneca had prior to Apotex's launch? 8 A. It represents a subset of the information 9 they had prior to launch. It's not comprehensive 10 with regard to all information they had. 11 Q. If you'll turn to page 6 of the document, 12 which is marked 185343, do you see a chart labeled 13 "omeprazole Situational Analysis"? 14 A. I do. 15 Q. And do you see it's for KUDCo, Mylan, Lek 16 and Prilosec? 17 A. Yes. 18 Q. And is it your understanding that this is 19 a comparison of the three generic manufacturers that 20 were on the omeprazole market at the time and 21 Prilosec? 22 A. The omeprazole product rather than market. 23 Q. But KUDCo, Mylan and Lek were actually 24 selling generic omeprazole at the time, by 25 October 3rd, 2003?</p>
<p style="text-align: right;">Page 60</p> <p>1 A. Yes. 2 Q. And if you look down to the third row, 3 where it says "Gross/Net Price Per Pill 4 (20 milligram 30 count)," do you see that row? 5 A. Yes, I do. 6 Q. And do you see where all the way on the 7 right, for Prilosec you have a gross of 3.69, a 8 lowest retail of 2.76 and a mail of 1.66? 9 A. Yes. 10 Q. And do you understand that as the WAC 11 cost, the cost less rebate, and then the cost to 12 mail order or the price to mail order? 13 A. I don't understand your question. 14 Q. Do you see the -- 15 A. Do I understand what? 16 Q. The three numbers. You see the gross, the 17 lowest retail and the mail. 18 A. Mail order. I presume that "Mail" is mail 19 order. 20 Q. Okay. 21 A. Okay? 22 Q. And the gross, what would that mean? 23 A. That would be the gross price before any 24 deductions, whether they be chargebacks, rebates, 25 discounts, other discounts.</p>	<p style="text-align: right;">Page 61</p> <p>1 Q. And then the lowest retail is 2.76. So 2 that would be minus any of those factors that you've 3 just listed? 4 A. No. I don't see anyplace on this document 5 where they show how they've computed the lowest 6 retail. So no, I don't know that it's netted out 7 all those factors. 8 Q. Do you have a reason to suspect that 9 they're not? That there's something else -- 10 A. No. 11 Q. -- that they would be -- 12 A. But I'm not -- 13 Q. -- getting for lowest retail? 14 A. Do I have any reason to believe they're 15 not? No. Do I have any reason to believe they are? 16 No. "No" on both counts. 17 Q. So when you look at the KUDCo and Mylan, 18 which also have different numbers in them, on that 19 same row -- 20 A. Yes. 21 Q. -- do you see where their mail order price 22 appears to be broken out? 23 A. Yes. 24 Q. All right. So that's: 25 "Mail order believed approximately 46</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 62..65

<p>Page 62</p> <p>1 cents." 2 Is that correct? 3 A. That's based, I presume, on their market 4 intelligence, which may or may not be correct. But 5 that's presumably what they've recorded here. 6 Q. And it's the market intelligence that 7 AstraZeneca had at the time? 8 A. Yes. 9 Q. And then this row indicates that both for 10 KUDCo and Mylan, there's a 2.70 gross price and then 11 a net price per pill of \$1.89 to \$2.30. Is that 12 correct? 13 A. That's what's recorded here, yes. 14 Q. And does that appear to record some form 15 of discount from the gross price per pill? 16 A. If there's a distinction -- and I presume 17 all the other documents make a distinction between 18 gross and net -- the answer would be yes. 19 Q. What would your understanding be of what 20 that distinction would rely on between gross and 21 net? 22 A. Well, first of all, they're looking across 23 all the channels; and the channels for the 24 distribution of volume, the pricing of those 25 channels is dramatically different.</p>	<p>Page 63</p> <p>1 So if I'm looking at mail order, mail 2 order particularly, as I point out in my 3 declaration, are often prescriptions written for 4 90 days, and mail order is usually among the low 5 price points within the channels that exist. The 6 retail channel is, generally speaking, the higher 7 price point. 8 And here, the actual recording of this 9 particular data for mail order, it's no surprise 10 that mail order is much lower and that market 11 intelligence would be correct, given all the data 12 that I've seen with regard to mail order. 13 It turns out that the amount of volume 14 moving through mail order is dramatically less than 15 what moves through the retail channel. So the 16 weighting of that particular price in terms of the 17 overall market price is very low; and as a result, 18 one can't rely on what's going on in mail order with 19 regard to determining what is the effective price 20 that third-party payers, that patients, that retail 21 pharmacy, any participants in the institutional 22 determination of value actually see. 23 Q. Okay. And before I go back to that 24 answer, you said "dramatically lower." Do you have 25 an understanding of the percentage of, say, Nexium</p>
<p>Page 64</p> <p>1 sales that go through mail order? 2 A. Yes, I've computed that. The -- I'd have 3 to go back and look at the data. I don't have that 4 memorized, but it's certainly well below 20 percent. 5 Q. So the answer that you just gave, you've 6 certainly broken out the mail order as generally 7 being a much lower price, both for generics and for 8 brandeds. 9 But what I'm asking about this gross/net 10 price per pill row is, there's a separation between 11 the gross price, the net price and then the mail 12 order price. Do you see that? 13 A. In the first two columns? Because it's 14 not with regard to Lek. 15 Q. Not -- exactly. But for KUDCo, for Mylan 16 and for Prilosec, all three of those break out a 17 gross price, a net price and a mail order price. Do 18 you see that? 19 A. Yes, I see that. This is their market 20 intelligence. This is not the actual data. 21 Q. This is -- fine. The question I was 22 asking is: Because they've broken out the mail 23 order price, it appears that the gross and net 24 prices for KUDCo and Mylan, they have a gross price 25 of 2.70 and then a net price of \$1.89 to \$2.30.</p>	<p>Page 65</p> <p>1 Does this indicate that they are offering 2 some sort of either rebate or discount off of their 3 gross price? 4 A. They -- no, it doesn't suggest they're 5 offering rebates off their gross price. It could be 6 they're offering chargebacks to wholesalers that 7 are -- these are wholesaler products. They may be 8 offering chargebacks to wholesalers. You don't know 9 that those are rebates. 10 Q. Okay. And can you explain the difference 11 between chargebacks and rebates as to -- actually, 12 just can you explain the difference there? 13 A. Rebates are a category that's used to 14 explain, as I think I've already testified here 15 today, the incentives that manufacturers offer to 16 managed care; and generally, those contracts specify 17 a base rebate along with additional incentives for 18 more rebates if larger volume is moved. 19 Chargeback, in contrast, are offered to 20 wholesalers to assure that they've got incentives to 21 move the product when there are discounts offered 22 downstream at the retail pharmacies. 23 So fundamentally, a wholesaler comes back 24 and says: You -- the manufacturer -- You've entered 25 into a contract with these retail pharmacies. The</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 66..69

<p style="text-align: right;">Page 66</p> <p>1 price that I've paid is, say, the wholesale 2 acquisition cost. And you've offered a discount 3 downstream, and I want to be made whole. 4 And as a result, the manufacturer gives 5 those wholesalers a chargeback. 6 Q. So with a chargeback . . . 7 I'm sorry. So in a situation with a 8 chargeback, are you saying that the generic 9 manufacturer has deals with pharmacies, retail 10 pharmacies themselves -- 11 A. May or may -- 12 Q. -- getting discounts? 13 A. I'm just giving you -- you asked what the 14 difference was. 15 Q. Yes. 16 A. I gave you a description of the 17 difference. I haven't seen any contracts produced 18 through discovery the generics have with retail 19 pharmacy. I'm giving you how the industry defines 20 "chargebacks" and how they arise and under what 21 conditions. 22 That would hold as well with regard to 23 Nexium and Prilosec. There are chargebacks. Look 24 at the P&Ls that are produced by AstraZeneca with 25 regard to Nexium and/or Prilosec, and you'll find</p>	<p style="text-align: right;">Page 67</p> <p>1 that they have actual recording of rebates versus 2 chargebacks versus other sorts of deductions against 3 the gross price. 4 Q. And did you review all of those various 5 deductions against the gross price in your analysis 6 of Nexium's price or just rebates? 7 A. Can you be more specific with regard to 8 which data? With regard to the IMS data? With 9 regard to the pharmacy logs? With regard to 10 AstraZeneca's P&Ls? Which data are we talking 11 about? 12 Q. When you ran your analysis comparing the 13 net cost of Nexium to the net cost of generic 14 omeprazole, did you look at all discounts or just 15 rebates? 16 A. I looked specifically at the position of 17 third-party payers. Third-party payers don't get 18 chargebacks. Hence, you wouldn't look at 19 chargebacks. 20 But implicitly, implicitly, if there are 21 chargebacks, then that would be reflected in the 22 reimbursement rate for the retail pharmacy with 23 regard to the dispensing. If there is a chargeback, 24 it would be built into the pricing. 25 Q. So whether this --</p>
<p style="text-align: right;">Page 68</p> <p>1 A. But the rebate would not be built into the 2 pricing that you see in terms of the pharmacy logs. 3 Q. Let's make this precise by looking at your 4 report. 5 A. I thought I was being precise. 6 Q. No, no. My next question. 7 A. Oh. 8 Q. So on page 14 of your report, at the 9 beginning -- in paragraph 26, under the heading C, 10 "Factors that Determine Effective Price of a Drug to 11 a Third Party Payer" -- 12 A. Yes. 13 Q. -- you set out the five factors as: 14 "(1) the pharmacy reimbursement, (2) the 15 consumer co-pay, (3) manufacturer rebates, 16 (4) the aggregate daily average 17 consumption rate for the drug, and (5) 18 free samples." 19 Did I read that correctly? 20 A. You did. 21 Q. Great. So I see No. 3, you break out 22 manufacturer rebates. 23 A. Yes. 24 Q. My understanding of what you've just said 25 about chargebacks is that that would affect the</p>	<p style="text-align: right;">Page 69</p> <p>1 pharmacy reimbursement. 2 A. Yes, that's correct. 3 Q. So whether these -- going back to -- I'm 4 sorry. 5 Going back to Exhibit 7, page 6, that row 6 that we've just been talking about, whether that 7 \$1.89 to 2.30 price is the result of a rebate or a 8 chargeback, either way that should affect the way 9 that you determine the net cost for the drug? 10 A. Yes. 11 Q. Did you consider chargebacks for generic 12 omeprazole in determining your net cost? 13 A. That's built in to the pharmacy 14 reimbursement rate. 15 Q. So that's already in the pharmacy log 16 data? That's what you're saying? 17 A. That's exactly what I'm saying. 18 Q. Okay. Going back to Exhibit 7 but this 19 time turning to page 7, this is 185344. Do you see 20 this chart? 21 A. I do. 22 Q. Okay. So this is the "WAC & Deepest 23 Rebate in HMO/PBMs." This is a chart that we've 24 just seen in another exhibit but for a different 25 time period; is that correct?</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 70..73

<p>Page 70</p> <p>1 A. Yes.</p> <p>2 Q. So this is a chart that AstraZeneca has</p> <p>3 put together October 3rd, 2003?</p> <p>4 A. Well, I presume they put it together</p> <p>5 sometime before that, but --</p> <p>6 Q. So this is --</p> <p>7 A. -- they reported it --</p> <p>8 Q. -- information --</p> <p>9 Thank you.</p> <p>10 A. They reported it on October 3.</p> <p>11 Q. This is information that they had prior to</p> <p>12 Apotex's launch?</p> <p>13 A. Yes.</p> <p>14 Q. And do they indicate that they know of</p> <p>15 rebates that are being paid for generic omeprazole?</p> <p>16 A. My response for this particular graph is</p> <p>17 exactly the same as it was for the graph that you</p> <p>18 asked me about in Rausser Exhibit 6.</p> <p>19 Q. And your response is that it's unreliable?</p> <p>20 A. It's unreli- -- yes, indeed. It's</p> <p>21 unreliable, first of all.</p> <p>22 Secondly, any rebates, as I indicated, for</p> <p>23 omeprazole, the only evidence is if there are any</p> <p>24 rebates, it's only with regard to the mail order</p> <p>25 channel, which is a very small channel in terms of</p>	<p>Page 71</p> <p>1 the total volume of product moving through the</p> <p>2 market, number one.</p> <p>3 And number two, the "deepest rebate"</p> <p>4 doesn't mean anything. You can have extreme values.</p> <p>5 You can have instances where there is a one-off deal</p> <p>6 that is not systematic within the marketplace. So</p> <p>7 it's meaningless. This is unreliable.</p> <p>8 Q. Did you, in coming to the conclusion that</p> <p>9 there were no rebates for generic omeprazole, review</p> <p>10 the documents produced by Apotex in this case?</p> <p>11 A. Review the documents produced by Apotex.</p> <p>12 Yes, I certainly look at -- looked at them, yes.</p> <p>13 Q. But that's not reflected in your Exhibit C</p> <p>14 to your declaration?</p> <p>15 A. No, because even though I reviewed it, I</p> <p>16 didn't rely on it with regard to my analysis that's</p> <p>17 reported in that declaration.</p> <p>18 Q. Do you understand that you're supposed to</p> <p>19 report everything you considered, not just what you</p> <p>20 relied upon?</p> <p>21 MR. ANDERSON: Objection; calls for a</p> <p>22 legal conclusion.</p> <p>23 THE WITNESS: My understanding is that in</p> <p>24 my report it's self-contained with regard to the</p> <p>25 information that I relied upon and I cited in my</p>
<p>Page 72</p> <p>1 report.</p> <p>2 With regard to the Apotex that you just</p> <p>3 asked me about, I don't believe I reviewed that</p> <p>4 before my declaration. That was something that I've</p> <p>5 looked at subsequently.</p> <p>6 BY MS. KINBURN:</p> <p>7 Q. Oh, thank you for the clarification.</p> <p>8 So you did not, prior to submitting at</p> <p>9 least your initial declaration, view any Apotex data</p> <p>10 to determine whether Apotex was, in fact, offering</p> <p>11 rebates?</p> <p>12 A. No. I did, however, in my prior Nexium</p> <p>13 work, I did interview AstraZeneca officials about</p> <p>14 whether, in fact, there were any rebates offered by</p> <p>15 generics, including Apotex or Mylan or any other</p> <p>16 generics that were out there; and they made it</p> <p>17 crystal-clear that the only rebates they were</p> <p>18 offering was with respect to the mail order channel.</p> <p>19 Q. And I believe that you've mentioned that</p> <p>20 you did not take into consideration mail order when</p> <p>21 running your analysis. Is that correct?</p> <p>22 A. When running -- I did not take into</p> <p>23 account mail order, no. I'm looking at retail</p> <p>24 pharmacies. You've seen the sample, and I've</p> <p>25 specified where the sample was concentrated, what</p>	<p>Page 73</p> <p>1 data was collected, and it did not include mail</p> <p>2 order.</p> <p>3 Q. And is there a point at which you would</p> <p>4 think that not including mail order would -- when I</p> <p>5 say "a point," a volume of Nexium going through mail</p> <p>6 order that would necessitate including mail order in</p> <p>7 your analysis?</p> <p>8 A. No. No, not at all.</p> <p>9 Q. So if 75 --</p> <p>10 A. The best --</p> <p>11 Q. -- percent went through it, that would not</p> <p>12 be necessary to review mail order?</p> <p>13 A. Certainly, if 75 percent went through it,</p> <p>14 but 75 percent did not go through it. Not even</p> <p>15 close. In fact, a very small percentage, as I</p> <p>16 specified earlier, went through mail order.</p> <p>17 Q. If you could take a look at Exhibit 6,</p> <p>18 this is the Nexium SCO brainstorm meeting.</p> <p>19 A. Are we through with 7, or should I hold it</p> <p>20 here?</p> <p>21 Q. Hold on to it. You never know when you're</p> <p>22 going to come back.</p> <p>23 I'm looking at page 13.</p> <p>24 A. 13?</p> <p>25 Q. And this is as of August 3rd, 2004.</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 74..77

<p style="text-align: right;">Page 74</p> <p>1 A. I'm looking at it. Is there a question?</p> <p>2 Q. Yeah. Do you see there's the PPI market</p> <p>3 in general, Nexium, Prevacid and Protonix? And</p> <p>4 those are in a chart form? And Nexium is the second</p> <p>5 column?</p> <p>6 A. Yes, I do see that.</p> <p>7 Q. Okay. Do you see how mail order is the</p> <p>8 second from the bottom? And this is a percentage of</p> <p>9 volume of these various PPIs that run through these</p> <p>10 channels.</p> <p>11 A. Yes.</p> <p>12 Q. Do you see where it shows 24 percent of</p> <p>13 Nexium's volume going through mail order?</p> <p>14 A. I do.</p> <p>15 Q. And do you still consider that too small a</p> <p>16 percentage to necessitate including in your</p> <p>17 analysis?</p> <p>18 A. Yes, for the following reason: This is in</p> <p>19 '04, and if you're coming up to the hypothetical</p> <p>20 negotiation, the IMS data reports this share for</p> <p>21 Nexium being much lower than what's recorded here.</p> <p>22 Q. And do you know what that was?</p> <p>23 A. You've already asked me that question, and</p> <p>24 I've told you what I recall.</p> <p>25 Q. Okay. So you recall it being a little</p>	<p style="text-align: right;">Page 75</p> <p>1 less than 20 percent?</p> <p>2 A. Yes.</p> <p>3 MS. KINBURN: Do we need to take a break</p> <p>4 to change out the video?</p> <p>5 THE VIDEOGRAPHER: Sure, anytime.</p> <p>6 MS. KINBURN: Might as well.</p> <p>7 THE VIDEOGRAPHER: This now ends Tape</p> <p>8 No. 1 in the video deposition of Gordon Rausser. We</p> <p>9 are going off the record at 11:14.</p> <p>10 (Recess taken.)</p> <p>11 THE VIDEOGRAPHER: This marks the</p> <p>12 beginning of Tape No. 2 in the video deposition of</p> <p>13 Gordon Rausser. We are now back on the record at</p> <p>14 11:31.</p> <p>15 BY MS. KINBURN:</p> <p>16 Q. Dr. Rausser, I believe that we have spoken</p> <p>17 before about the fact that there were a number of</p> <p>18 PPIs in the market at the time in 2002-2003 and</p> <p>19 that, as I believe you said, third-party payers</p> <p>20 would have taken into consideration the cost and</p> <p>21 efficacy of these various PPIs in determining where</p> <p>22 to place them on their formulary. Is that accurate?</p> <p>23 A. You said cost as well?</p> <p>24 Q. Cost --</p> <p>25 A. Yes.</p>
<p style="text-align: right;">Page 76</p> <p>1 Q. -- and efficacy?</p> <p>2 A. Yes. Their net cost.</p> <p>3 Q. You've already stated that Nexium really</p> <p>4 sold itself on its efficacy, on the fact that it was</p> <p>5 the gold standard.</p> <p>6 A. Relative to Prilosec.</p> <p>7 Q. Relative to Prilosec.</p> <p>8 How did that -- how would that have</p> <p>9 factored into the third-party payers' decisions for</p> <p>10 what formulary status to give it?</p> <p>11 A. Everything else constant, the greater</p> <p>12 efficacy would place it on a more favorable tier,</p> <p>13 everything else constant.</p> <p>14 Q. And do you know or have you investigated</p> <p>15 how the net cost of Nexium compares to the other</p> <p>16 PPIs, the other branded PPIs?</p> <p>17 A. First of all, that's not possible -- I've</p> <p>18 already told you that earlier today -- because you</p> <p>19 don't have the net prices for the other PPIs. To</p> <p>20 get those net prices, you need rebates and</p> <p>21 chargebacks. That's proprietary information that is</p> <p>22 not reported by IMS. You would have to have access</p> <p>23 to their product-specific P&Ls.</p> <p>24 And that information or that data was not</p> <p>25 available to me at the time of my reports in this</p>	<p style="text-align: right;">Page 77</p> <p>1 matter, or was it available to me in the two earlier</p> <p>2 reports that I filed on Nexium.</p> <p>3 Q. Is that information, the net cost of these</p> <p>4 various PPIs, information that would have been</p> <p>5 available to the third-party payers when they were</p> <p>6 making their decisions?</p> <p>7 A. Certainly. They would have known what the</p> <p>8 rebates were that were being offered by those</p> <p>9 specific PPIs.</p> <p>10 I have -- in the pharmacy log data, I have</p> <p>11 other transactions in which there was transactions</p> <p>12 for those PPIs, other PPIs aside from Nexium and</p> <p>13 omeprazole, but that wasn't the purpose for my</p> <p>14 analysis. So I did not look and/or summarize that</p> <p>15 from the pharmacy log data.</p> <p>16 However, the pharmacy log data has been</p> <p>17 produced. One can certainly look at what is the net</p> <p>18 price reported for those transactions related to</p> <p>19 other PPIs.</p> <p>20 Q. Your opinion with regard to the net cost</p> <p>21 of Nexium is that a third-party payer would be more</p> <p>22 likely to place Nexium on a favorable formulary</p> <p>23 status if its cost, its net cost was less than</p> <p>24 omeprazole, generic omeprazole; is that correct?</p> <p>25 A. Yes, certainly, that is correct. But in</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 82..85

<p>Page 82</p> <p>1 the net cost, no. I was asked only to evaluate 2 those two products with regard to third-party 3 payers. 4 In my earlier analysis, as I've already 5 testified, I looked at all the PPIs with respect to 6 the market dynamics, the substitutability, the 7 switching from one drug to another. I looked at 8 switching data. 9 That's not relevant here. We come into 10 the hypothetical negotiation, that's all given. 11 There is a perspective, a lens on that market 12 dynamics that AstraZeneca has. And I'm looking at a 13 fundamental question: Would they be worse off after 14 the entry of Apotex vis-a-vis where they stood 15 before? 16 And one distinct advantage they had before 17 is they could offer more incentives to third-party 18 payers to capture more volume for Nexium, which is 19 their fundamental value proposition at that point in 20 time in the marketplace, not Prilosec or not 21 Prilosec OTC, either. 22 Q. From a purely net cost perspective, would 23 the other PPIs, particularly Protonix and Prevacid, 24 having a lower net cost than Nexium affect the 25 advantage that you see Nexium having by being net</p>	<p>Page 83</p> <p>1 cost cheaper than generic omeprazole? 2 A. I can't answer the question without 3 knowing the third-party payer, what is the 4 foundation that they have with regard to the science 5 and whether Nexium has superior efficacy versus the 6 other PPIs. And that's not something that you've 7 specified in your question, so I can't answer the 8 question. 9 Q. I think I said on a purely net cost basis. 10 A. Well, there is no purely net cost basis. 11 You don't make choices on a purely net cost basis. 12 Q. But the advantage that you've put in your 13 analysis is based purely on the relative costs of 14 generic omeprazole and Nexium; is that correct? 15 A. That is correct. And I've represented to 16 you that AstraZeneca makes representations about the 17 superior efficacy of Nexium. There are other 18 elements of the market that argue that there is no 19 incremental efficacy of Nexium. These are 20 assertions that are out in the marketplace. 21 In fact, the prior case and all the work I 22 did with respect to Nexium was based on the 23 plaintiffs' assertion that there is no difference 24 from Nexium and Prilosec. So in their perspec- -- 25 from their perspective, the efficacy differential is</p>
<p>Page 84</p> <p>1 zero. 2 Q. What I'm asking is, given the fact that 3 you do not factor in efficacy into your comparison 4 of generic omeprazole and Nexium, why you believe 5 that would be necessary in order to compare net 6 costs on a hypothetical basis. 7 A. I'm sorry. I don't understand your 8 question. 9 You're not going to get me to answer a 10 question that cherry-picks part of the 11 decision-making process with regard to trade-offs. 12 I'm not going to do it. 13 If you want to specify a complete 14 hypothetical, taking into account what the PT 15 committees or the third-party payers have evaluated 16 with regard to efficacy and the trade-offs on that 17 efficacy and then I can measure the incremental cost 18 against it, I could give you an answer to your 19 question. But aside from that, you're not going to 20 get an answer from me. I'm sorry. 21 Q. Did you take all of that into 22 consideration in comparing the cost of generic 23 omeprazole and Nexium? 24 A. My report stands within the four corners 25 of each page of the report. It looks specifically</p>	<p>Page 85</p> <p>1 at what is the advantage to third-party payers of 2 having to reimburse for Nexium versus omeprazole 3 from a cost perspective. That's it. 4 Q. Now, we've discussed paragraph 26 of your 5 report, which lays out the five different factors 6 that you take into consideration in creating your 7 net cost number. Is that correct? 8 A. That is correct. 9 Q. And one of those is free samples; is that 10 right? 11 A. Yes, that is correct. 12 Q. And in your calculation, you take a 13 hundred percent of the free samples that you have 14 data for and you subtract that or you net that out 15 of the cost of Nexium; is that correct? 16 A. Yes. 17 Q. Do you have an understanding as to how 18 many of those free samples actually go to lives 19 covered by third-party payers? 20 A. How much of the free samples -- no. IMS 21 simply reports in their promotion, marketing 22 documents that they publish with regard to free 23 samples, and that looks at the total free samples, 24 whether those free samples go to uninsured or 25 insureds. So the answer to your question, no, you</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 90..93

<p>Page 90</p> <p>1 MS. KINBURN: Can we just go off the 2 record for two seconds? 3 THE VIDEOGRAPHER: We're now going off the 4 record. The time is 12:04. 5 (Discussion off the record.) 6 THE VIDEOGRAPHER: We're now back on the 7 record. The time is 12:05. 8 THE WITNESS: These two studies you've 9 given me, more importantly, do not pertain to PPI 10 drugs. And I don't see, in either one of the two 11 studies, any differentiation with regard to the type 12 of therapies. They obviously are legitimately 13 concerned with those drugs that have serious side 14 effects, those that have potential for abuse or 15 dependence. 16 So I don't know of any studies for these 17 kinds of surveys that are attempting to determine 18 the ethical behavior of physicians with regard to 19 the PPI drugs. It's my understanding that they are 20 not subject to abuse and have any serious 21 dependence -- dependence issues. 22 Secondly, the real purpose of the free 23 samples is to expand the commercial base for a 24 particular therapy. And even if a physician 25 utilizes those free samples themselves or other</p>	<p>Page 91</p> <p>1 members of the staff use them, if they turn out to 2 be effective, it may lead to more prescriptions, 3 which is, in fact, the reason for the free samples 4 to begin with. 5 Coming back to your question that pertains 6 to my analysis, the free samples doesn't make any 7 difference anyway. 8 BY MS. KINBURN: 9 Q. Okay. If you could turn to page 6 of your 10 report -- actually, it's page 5 to 6. It's the 11 paragraph 11 of your summary conclusions. 12 A. Paragraph 11. I'm there. 13 Q. Okay. And in this paragraph, you talk 14 about the relative costs of Nexium and omeprazole 15 and formulary status where -- and this is at the 16 bottom of page 5: 17 "More costly drugs are likely to 18 receive less favorable formulary status, 19 which is associated with higher co-pays 20 and lower sales." 21 And so the last sentence of your paragraph 22 is: 23 "Loss of this advantage could have 24 threatened Nexium's favorable formulary 25 status and its market share."</p>
<p>Page 92</p> <p>1 That is your opinion; is that correct? 2 A. That's certainly my opinion. 3 Q. And you rely on Dr. Navarro and his 4 declaration in discussing formulary status, is that 5 correct, or is this from your own understanding and 6 knowledge? 7 A. It's certainly from his report or 8 declaration, but it's from my own understanding and 9 all the work that I've done over the last 20-plus 10 years in this industry, and the work specifically 11 with regard to all of the analysis that I've 12 conducted; as I indicated, more than 40, as many as 13 60 cases in which the question of formulary status 14 and net cost to third-party payers is crucial. 15 Q. And can you define "favorable formulary 16 status"? 17 A. Certainly. There's huge variability in 18 terms of managed care and/or third-party payers with 19 regard to formulary; but a simple lens along the 20 determination of formularies is that most managed 21 care operate with three basic tiers. Now, there's 22 some -- there's a lot of variation. Some have four, 23 five tiers, but most operate with three tiers. 24 The distinguishing characteristics of the 25 tiers with regard to the ultimate patient population</p>	<p>Page 93</p> <p>1 or the covered lives is: What is the co-pay? 2 And the co-pay is generally the lowest for 3 Tier 1. All the generics sit at that tier. Tier 2 4 has a higher co-pay. There are branded drugs there 5 and many of which offer some incentives for being in 6 that particular tier. There's Tier 3. 7 And then there's variations in terms of 8 the formulary. There can be pre-authorization. 9 There can be specific qualifications that have to be 10 satisfied. 11 Prevacid, for example, in some data that I 12 saw in the Nexium matter, there were instances where 13 some of the formularies actually had to -- for each 14 of their covered lives, had to try some other PPI 15 before they could turn to Prevacid. That was also 16 true on some formularies with regard to Aciphex as 17 well. 18 So there are other sorts of control levers 19 that managed care has with regard to authorizing 20 some portion of the reimbursement for a dispensed 21 therapy by a retail pharmacy. 22 Q. Okay. And as I believe you've said, 23 co-pays are determined by the formulary tier that a 24 drug is on? 25 A. Generally speaking, yes. There is a lot</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 134..137

<p style="text-align: right;">Page 134</p> <p>1 status, you can certainly do so. You'd have to go 2 and look at the actual underlying contracts that 3 AstraZeneca has with these third-party payers that 4 are revealed in the pharmacy logs. 5 Those contracts exist. In the prior 6 cases, I've reviewed those contracts. And those 7 contracts will tell you what is the formulary status 8 after the rebates. I think some of them will also 9 tell you what they were before. 10 So you can look at: Gee whiz, what was 11 the benefit of the bargain? They offered this in 12 the way of rebates and now they're on Tier 2. 13 I don't recall any contracts where they 14 moved to Tier 1. There may be some, but I don't 15 recall seeing any of those contracts. 16 But when they offered the rebate, what 17 happens then is that they're on this -- at least 18 with regard to the cost dimension, for some of the 19 managed care third-party payers, they're on the same 20 playing field as omeprazole. 21 Q. When you say "they're on the same playing 22 field as omeprazole," do you mean the same tier? 23 A. No. I mean the same effective cost. 24 Q. Same effective cost? 25 A. Yeah.</p>	<p style="text-align: right;">Page 135</p> <p>1 Q. All right. Going back to your report, 2 page 3, paragraph 6. 3 A. Yes. 4 Q. You note that a previous version of your 5 analysis was included in declarations from 2008 6 submitted in James Weiss, et al. versus AstraZeneca 7 in California, and Commonwealth Care Alliance versus 8 AstraZeneca in Massachusetts. Is that correct? 9 A. Yes, it is. 10 Q. In the James Weiss case, your conclusions 11 were just with regard to the price of Nexium and 12 generic omeprazole in California; is that correct? 13 A. The sample of pharmacies in the state of 14 California, yes. 15 Q. And in the Commonwealth case, your samples 16 were, likewise, drawn from Massachusetts; is that 17 correct? 18 A. That is correct. 19 Q. Do you believe that the analysis you did 20 for these two and the data that you pulled for these 21 two cases is generalizable or applicable to the 22 entire United States market? 23 A. I've seen no evidence that it isn't. In 24 particular, many of those third-party payers operate 25 throughout the country; and they -- with regard to</p>
<p style="text-align: right;">Page 136</p> <p>1 the AstraZeneca offer of rebates for creating 2 incentives for moving more volume by managed care, 3 they generally offered that to the entire 4 marketplace. Some of the managed care third-party 5 payers accepted the offer and/or renegotiated and 6 some didn't. 7 But yes, I would expect the implications 8 of this to exist throughout the country, and I have 9 seen no evidence to suggest otherwise. 10 Q. Just to confirm, it's your understanding 11 that AstraZeneca offered the same rebates to all of 12 the third-party payers throughout the United States? 13 A. Let's be careful about "offer." There's 14 an offer; there's an ask; there's a negotiation 15 process that goes on. 16 It's my understanding that they offered a 17 generic version to all managed care, but then there 18 was negotiation that went on that resulted in a 19 contractual relationship. It wasn't the same 20 contractual relationship with respect to each and 21 every third-party payer. 22 But if, for example, Blue Cross/BlueShield 23 got this specific relationship with AstraZeneca with 24 regard to rebates, Blue Cross/BlueShield in Alabama 25 would also get the same kind of contractual</p>	<p style="text-align: right;">Page 137</p> <p>1 relationship, if desired by them. 2 And that can be confirmed by simply 3 looking at the underlying contracts that are 4 revealed in a summary fashion by AstraZeneca's P&L 5 for Nexium, because they include an aggregate rebate 6 number, but lying behind that is all the contractual 7 relationships that they have throughout the country. 8 MS. KINBURN: I'd like to mark this next 9 exhibit as Exhibit 14. 10 (Whereupon, Deposition Exhibit 14 was 11 marked for identification.) 12 MS. KINBURN: And for the record, this is 13 an SK&A consumer access to pharmacies in the United 14 States from the year 2007. 15 BY MS. KINBURN: 16 Q. You can look at whatever you like. I'm 17 looking at page 3. 18 A. All right. 19 Q. Okay. And so on page 3 of that document, 20 the words at the very top show Figure 1 as: 21 "Nearly 59,000 Retail Pharmacies 22 Operate in the United States." 23 Is that correct? 24 A. That's what it says. 25 Q. All right. And do you have reason to</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 138..141

<p style="text-align: right;">Page 138</p> <p>1 believe that that would be significantly different 2 from 2003, when you ran your -- when you pulled your 3 data for the report? 4 A. Significantly different in terms of 5 numbers? 6 Q. Yes. 7 A. I have no knowledge to suggest it would be 8 significantly different. 9 Q. Okay. And this figure shows that 10 Massachusetts had approximately 1,077 pharmacies. 11 It's in the -- 12 A. I see. Yes. 13 Q. And then California had 5,350; is that 14 correct? 15 A. That's what it says, yes. 16 Q. Okay. How many pharmacies did you pull 17 data from for your analysis? 18 A. The sample size was 30. 19 MS. KINBURN: I believe we need to break 20 in a minute, so I think this would be a good point. 21 THE WITNESS: Okay. 22 THE VIDEOGRAPHER: This now ends Tape 23 No. 2 in the video deposition of Gordon Rausser. 24 We're now off the record at 2:21. 25 (Recess taken.)</p>	<p style="text-align: right;">Page 139</p> <p>1 THE VIDEOGRAPHER: This marks the 2 beginning of Tape No. 3 in the video deposition of 3 Gordon Rausser. We are now back on the record at 4 2:40 -- excuse me -- :33. 5 BY MS. KINBURN: 6 Q. All right. Dr. Rausser, in conducting 7 your analysis for this case, did you include any 8 additional data that you did not use in your James 9 and Commonwealth cases? 10 A. Additional data? 11 Q. I'm sorry. Additional pharmacy log data. 12 A. No. It's the same data. The pharmacy log 13 data was the same data. 14 Q. Did you -- how did you decide to rely just 15 on the data that you had collected in those previous 16 two cases? 17 A. How did I decide to rely? 18 Q. Did you put any thought to whether that 19 data would be sufficient to speak for the entire 20 United States? 21 A. Did I give any thought? I certainly did. 22 In my -- I actually referred to the sample and the 23 limited nature of the sample; however, that it was 24 the best available information to analyze the 25 question that I was asked to evaluate.</p>
<p style="text-align: right;">Page 140</p> <p>1 And we all know that there are lots of 2 prices out there in the pharmaceutical industry, 3 many of which do not relate to actual transactions. 4 This is the best available data on the question that 5 I've been assigned that goes to actual transactions. 6 Q. What would be the best unavailable data on 7 that question, if in the best of all possible worlds 8 you had access to whatever data you wanted? 9 A. Well, now you're -- you have to take into 10 account the cost. I'm assuming there's no budget 11 constraints. 12 Q. Yes. No confidentiality constraints. You 13 can just get whatever you need. 14 A. Well, the best -- under those 15 circumstances, if -- unrealistically, if you presume 16 that you could get whatever data you want, you'd 17 want all of the pharmacy logs because that's where 18 the actual transactions take place. 19 And that would be prohibitively expensive. 20 I don't know that anybody ever -- has ever gone out 21 and collected all of the primary transactions with 22 regard to each and every pharmacy in the country. 23 But a complete population, under your structure in 24 which cost doesn't matter, you'd collect all the 25 primary transactions.</p>	<p style="text-align: right;">Page 141</p> <p>1 Q. And if you hadn't been relying on the two 2 previous data collections, would you have chosen 3 other pharmacies to collect your data from? 4 A. That's not a question I've given any 5 thought to. There is significant cost of collecting 6 just this data. And I know of no other instance 7 where, within the pharmaceutical industry, someone 8 has gone out and collected -- designed a sample, 9 gone out, done a random selection of the pharmacies, 10 collected and summarized the data in a litigation 11 dispute of this type. So that was certainly an 12 important issue in the Nexium matter. 13 In this particular matter, looking at the 14 benefits versus cost and whether this information 15 was sufficient for the question that I was asked to 16 analyze, it's sufficient for the purposes of the 17 question that was put to me. 18 Q. Okay. And just for clarity of the record, 19 what exactly was that question again? 20 A. I specify right up-front. 21 "I was engaged by counsel for the 22 plaintiffs . . . to compute third 23 party . . . cost per day of therapy for 24 two drugs, Nexium and generic 25 omeprazole"</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 142..145

<p style="text-align: right;">Page 142</p> <p>1 That's the question.</p> <p>2 But then with regard to my expertise in</p> <p>3 economics, my understanding of the industry, the</p> <p>4 strategies that are used by generics versus branded</p> <p>5 pharmaceutical companies, the structure of the</p> <p>6 institutions, what managed care does with regard to</p> <p>7 entering into contractual relationships on rebates</p> <p>8 and offering volume increases, that all too is</p> <p>9 related to taking that analysis into an opinion that</p> <p>10 I've expressed in my report.</p> <p>11 Q. You mentioned designing a sample. Not in</p> <p>12 this last answer, but the one before.</p> <p>13 If you had not been working off of the</p> <p>14 James Weiss and Massachusetts Commonwealth data</p> <p>15 sets, how would you have designed a sample to sample</p> <p>16 these pharmacy logs?</p> <p>17 A. If what? What was the first part?</p> <p>18 Q. If you hadn't been relying on the</p> <p>19 California and Massachusetts cases.</p> <p>20 A. By the way, I can't answer that question.</p> <p>21 It depends on what the purpose is for your analysis.</p> <p>22 You can't ask a generic question about if you could</p> <p>23 satisfy any wish that you want to specify. I have</p> <p>24 to know what the purpose is.</p> <p>25 You don't go out and collect a sample.</p>	<p style="text-align: right;">Page 143</p> <p>1 You don't do an analysis of a sample and draw</p> <p>2 inferences for the complete population unless you</p> <p>3 have a purpose. What's the purpose for the</p> <p>4 analysis?</p> <p>5 I told you what my purpose was. My</p> <p>6 purpose is to compare the third-party cost of</p> <p>7 therapy for two different drugs. Given that that's</p> <p>8 my purpose, is the data here sufficient for that</p> <p>9 purpose? Yes, it is.</p> <p>10 Q. The question I'm asking --</p> <p>11 A. If you want to -- I'm sorry. If you want</p> <p>12 to change the purpose and give me another purpose</p> <p>13 and ask me the question what data would I want to</p> <p>14 collect, whether I could use secondary data or</p> <p>15 whether I could use IMS data or whether I could use</p> <p>16 AstraZeneca's own internal documents, then certainly</p> <p>17 the data that I'd want to analyze is different if</p> <p>18 the question's different.</p> <p>19 Q. Given the same question you were asked in</p> <p>20 this case, in a hypothetical world where you had not</p> <p>21 previously run an analysis or gathered data, the</p> <p>22 pharmacy log data for the previous California and</p> <p>23 Massachusetts cases, would you have pulled from the</p> <p>24 same pharmacies to collect your pharmacy log data?</p> <p>25 A. No, because I would have -- no, because it</p>
<p style="text-align: right;">Page 144</p> <p>1 turns out that when I do a random selection of which</p> <p>2 pharmacies to subpoena, it would have been a</p> <p>3 different selection.</p> <p>4 That's how you do random sample surveys.</p> <p>5 You actually end up doing a new random selection.</p> <p>6 No, they wouldn't be the same.</p> <p>7 Q. I recognize that a random selection of</p> <p>8 different -- I'm sorry -- of the same population is</p> <p>9 going to get you --</p> <p>10 A. Right.</p> <p>11 Q. -- different results.</p> <p>12 Right?</p> <p>13 A. Right.</p> <p>14 Q. So if we're just looking in California and</p> <p>15 you were doing a random selection of California</p> <p>16 pharmacies, each time you pulled it, it would be</p> <p>17 different. That's what randomness --</p> <p>18 A. Yes.</p> <p>19 Q. -- creates.</p> <p>20 A. Yes.</p> <p>21 Q. There's a difference between the</p> <p>22 randomness you get within a set and randomness you</p> <p>23 get between sets that are different. Is that</p> <p>24 correct?</p> <p>25 So you'd get different random selections</p>	<p style="text-align: right;">Page 145</p> <p>1 from only California than you would from the United</p> <p>2 States as a whole?</p> <p>3 A. In other words -- let me see if we can</p> <p>4 change this. If in terms of the universe from which</p> <p>5 I'm selecting the random selection, if it's beyond</p> <p>6 just California and Massachusetts, certainly I would</p> <p>7 get a different random selection than I would if I</p> <p>8 just restricted it to Massachusetts and California.</p> <p>9 Certainly.</p> <p>10 Q. And the selection -- let's restrain this</p> <p>11 part of the discussion just to California pharmacy</p> <p>12 logs. Not all of those pharmacies were picked as a</p> <p>13 result of random draw; is that correct?</p> <p>14 A. No, I don't believe that is correct. We</p> <p>15 did certainly stratify it. So when you say it</p> <p>16 wasn't purely random, we did end up wanting</p> <p>17 representation that was stratified.</p> <p>18 We wanted chain pharmacies. We wanted at</p> <p>19 least some local pharmacies to be included. We</p> <p>20 wanted certainly a mass retail store that has</p> <p>21 pharmacies. So it was stratified to that degree.</p> <p>22 Q. Do you have a recollection that at least</p> <p>23 one of the pharmacy chains that you -- I'm sorry --</p> <p>24 pharmacy locations that you picked was picked</p> <p>25 because one of the representative plaintiffs had</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 146..149

<p style="text-align: right;">Page 146</p> <p>1 made a purchase there?</p> <p>2 A. Yes. Certain- -- certainly that was one</p> <p>3 of the issues with regard to the plaintiffs, named</p> <p>4 plaintiffs, yes.</p> <p>5 Q. So that -- so that would not have been a</p> <p>6 random selection?</p> <p>7 A. There was a constraint with regard to the</p> <p>8 sample selection to at least encompass, to the</p> <p>9 degree we could, who were the named plaintiffs.</p> <p>10 But there's not a shred of evidence to</p> <p>11 suggest that the results for those pharmacies that</p> <p>12 were located or frequented by those named plaintiffs</p> <p>13 are non- -- non-representative. I don't know of any</p> <p>14 evidence along those lines.</p> <p>15 Q. Did you run any statistical analysis or</p> <p>16 any other analysis to determine the</p> <p>17 representativeness of the 30 pharmacies that you</p> <p>18 looked at?</p> <p>19 A. No. It's common sense. I mean, we looked</p> <p>20 at -- both in California and Massachusetts, we</p> <p>21 looked at stratification with regard to who are the</p> <p>22 dispensing pharmacies that are out there.</p> <p>23 To be able to analyze the inferences that</p> <p>24 are drawn from those, you would have to do repeated</p> <p>25 samples. And that's something that's very costly.</p>	<p style="text-align: right;">Page 147</p> <p>1 And the cost, at least based on my expertise in</p> <p>2 statistics, wouldn't be justified by the benefits</p> <p>3 that would be derived.</p> <p>4 And you can -- your experts can certainly</p> <p>5 check that by going out and collecting pharmacy logs</p> <p>6 from other pharmacies to see whether or not it is</p> <p>7 reliable from the standpoint of predicting the</p> <p>8 results you'd get from repeated samples.</p> <p>9 Q. You spoke about the stratification of your</p> <p>10 sample to make sure that you were hitting the</p> <p>11 various types of pharmacies. Is that correct?</p> <p>12 A. I'm sorry. Say that again, please.</p> <p>13 Q. I believe you discussed -- and please</p> <p>14 correct me if I'm imprecise -- that in creating a</p> <p>15 sample, it was not entirely random because you</p> <p>16 wanted to ensure that various types of pharmacies</p> <p>17 were represented. That would make it less random</p> <p>18 but much more representative of --</p> <p>19 A. That's --</p> <p>20 Q. -- the universe of pharmacies?</p> <p>21 A. That's the reference to the word</p> <p>22 "stratification."</p> <p>23 Q. Your data did not include either Walgreens</p> <p>24 or Rite Aid; is that correct?</p> <p>25 A. That's correct.</p>
<p style="text-align: right;">Page 148</p> <p>1 Q. And that's the third and first largest</p> <p>2 pharmacies in the United States; is that right?</p> <p>3 A. I'd have to go back and look at the data.</p> <p>4 I don't recall.</p> <p>5 Q. Taking that as true, would that have any</p> <p>6 effect on the representativeness of your sample if</p> <p>7 they're not included in your -- in your sample?</p> <p>8 A. Once again, this is the best available</p> <p>9 data, the data that I've used.</p> <p>10 If one goes out and collects a random</p> <p>11 sample from Rite Aid and Walgreens, the question is:</p> <p>12 Would that data show any difference?</p> <p>13 To the extent the document that you just</p> <p>14 showed me, namely, the most recent exhibit -- thank</p> <p>15 you -- about all the independent pharmacies and</p> <p>16 chain pharmacies, the argument that is advanced by</p> <p>17 this particular document is that there's a huge</p> <p>18 amount of access and there's a lot of competition</p> <p>19 among these various pharmacies. If that's the case,</p> <p>20 the pharmacies that are included in my sample are</p> <p>21 going to actually conduct themselves much the same</p> <p>22 way as all other pharmacies.</p> <p>23 So if you accept the argument that there's</p> <p>24 a competitive structure at the pharmacy level and</p> <p>25 consumer access, collecting Rite Aid and Walgreens</p>	<p style="text-align: right;">Page 149</p> <p>1 wouldn't change my results.</p> <p>2 Now, if there is some lack of competition</p> <p>3 within the services provided by pharmacies, maybe it</p> <p>4 would make some difference. But even so, given the</p> <p>5 question I was assigned, it's the best available</p> <p>6 information that exists today.</p> <p>7 For example, in urban areas -- right here,</p> <p>8 using their own words:</p> <p>9 "... consumers patronizing independents</p> <p>10 have access to 30 competing pharmacies</p> <p>11 within two miles of their current</p> <p>12 pharmacy."</p> <p>13 What that says is that there's a</p> <p>14 competitive landscape, and they're all going to</p> <p>15 provide services charging, in effect, the same value</p> <p>16 for their services. If they get out of line,</p> <p>17 consumers are going to go to where the best services</p> <p>18 are for the costs that they incur.</p> <p>19 Q. I believe you derive your conclusion</p> <p>20 regarding a significant number of third-party</p> <p>21 payers. Unfortunately, I can't seem to find the</p> <p>22 page that you say that on.</p> <p>23 Page 21. Your opinion here is that:</p> <p>24 "The economic evidence shows that in</p> <p>25 the period from December 2002 through</p>

<p style="text-align: right;">Page 154</p> <p>1 third-party payers who paid for a PPI or who just 2 paid for Nexium? 3 A. Who paid for Nexium, yes. 4 Q. So if a third-party payer paid for a lot 5 of Protonix but no Nexium, they wouldn't show up on 6 your data set? 7 A. That's correct, because they would be 8 outside of the purpose for the analysis that I 9 conducted. 10 Q. And then you took the 20 third-party 11 payers who had the largest shares of Nexium sales. 12 So you identified those 20? 13 A. Yes. 14 Q. And then you were only able to obtain 15 rebate data for 14 of them; is that correct? 16 A. That is correct. That's clarified at the 17 top of page 22. 18 Q. Yes. Did AstraZeneca not have rebate data 19 for six of these third-party payers? Is that what 20 happened? 21 A. There wasn't any data with regard to a 22 subset of the third-party payers. 23 Q. Is it possible that AstraZeneca simply 24 wasn't paying rebates to them? 25 A. Certainly it's possible. It's possible</p>	<p style="text-align: right;">Page 155</p> <p>1 that Nexium wasn't on their formulary too. 2 Q. But they did cover -- they were one of the 3 20 third-party payers responsible for the largest 4 share of Nexium? 5 A. Yes. But now the question is the data 6 itself. What does the data itself show with regard 7 to matching up that data with regard to 8 AstraZeneca's reported contractual relationships 9 with third-party payers and what they paid them in 10 the way of rebates? 11 Q. AstraZeneca didn't have contractual 12 relationships with every third-party payer, is that 13 correct, for Nexium? 14 A. I don't believe they did, no. But in 15 terms of looking at the universe of all potential 16 and what their contracts were, I didn't go through a 17 matching process. I simply looked at what these 18 third-party payers that appeared on the transaction 19 and whether there was any rebates offered to them. 20 Q. So when you calculate the cost to 21 third-party payers, you exclude six of the 20 top 22 third-party payers when it comes to the proportion 23 of Nexium purchases on the basis that you didn't see 24 that AstraZeneca had given them any rebates? 25 A. I don't have any rebate data for it, so I</p>
<p style="text-align: right;">Page 156</p> <p>1 can't very well look at the actual incentives with 2 regard to those third-party payers. 3 What I'm concerned about and the purpose 4 for my analysis is to look at how the world's going 5 to change if there is a new generic that is 6 introduced to the market. What is going to happen 7 to AstraZeneca with regard to the amount of 8 compensation they're going to have to offer to the 9 managed care for which they're offering rebates, 10 whether there's any incremental -- or the incentives 11 for incremental rebates to be offered to them. And 12 I only used those actual observations for which 13 there was rebate data that was available. 14 Q. So your conclusions about the relative 15 cost of Nexium versus generic omeprazole are limited 16 to the cost to third parties with whom AstraZeneca 17 was in a contractual relationship, offering rebates? 18 A. Yes, because that would go to the question 19 of would that equilibrium that existed prior to the 20 hypothetical negotiation, would that equilibrium be 21 changed as a result of a new entrant and a lower 22 cost, a lower potential cost of omeprazole, which 23 would in turn, in the new equilibrium, require one 24 of two things: either less volume being moved 25 through the market or more rebates being offered?</p>	<p style="text-align: right;">Page 157</p> <p>1 Q. So the calculation you run on the cost to 2 third-party payers of Nexium is not representative 3 even of all of the 30 -- I'm sorry -- of the 20 4 third-party payers who were responsible for the 5 largest share of Nexium sales because you exclude 6 any third-party payer who did not receive a rebate. 7 And as a result, wouldn't that 8 significantly change your results? 9 A. Why? It doesn't change my results for the 10 purposes for which I conducted the analysis. 11 The purpose of the analysis is for those 12 third-party payers that receive some incentive for 13 moving volume, and the incentive is rebates, and 14 would that equilibrium change as a result of a new 15 generic being on the marketplace? That's the 16 purpose for the analysis. 17 You can ask all sorts of questions talking 18 about general purposes or other purposes that might 19 arise that you would be interested in. But those 20 are not the purposes for which I did my analysis. I 21 specify quite clearly what my purpose was. 22 So given my purpose, a third-party payer 23 that is getting nothing in the way of incentives 24 from Nexium is not relevant to my analysis. 25 Q. Is there anything stopping AstraZeneca</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 158..161

<p style="text-align: right;">Page 158</p> <p>1 from entering into contractual relationships with 2 those six third-party payers that are not included 3 in your sample? Is there any reason that they could 4 not enter into that sort of relationship? 5 A. In the future? 6 Q. Yes. 7 A. Depending on what the incentives are, 8 certainly it's possible. 9 Q. And just looking at the last sentence in 10 paragraph 41, you note that not all of these payers 11 were present in the pharmacy logs for both states, 12 reflecting that health plans are often regional in 13 nature. Is that correct? 14 A. Yes, that's what the sentence says. Some 15 health plans were regional; some are national. 16 Certainly. 17 Q. Okay. And does that give you any pause 18 with regard to the representativeness of these 30 19 pharmacies from two states to represent the entire 20 United States? 21 A. No, not with regard to, No. 1, the 22 purposes for my analysis; and No. 2, what is the 23 best available information. 24 Is there any information out there that's 25 better than this information with regard to drawing</p>	<p style="text-align: right;">Page 159</p> <p>1 inferences for the entire United States? I'm not 2 aware of it. 3 Q. In paragraph 42, but over on page 23 -- 4 it's the end of the paragraph -- you note that: 5 "For several of the top 14 third party 6 payers, there were no months where there 7 was pharmacy log data for both drugs under 8 comparison, and these third party payers 9 were removed from the tables." 10 How many of those -- how many of the 14 11 were removed from the data? 12 A. I have to go back and look. I'm sorry. I 13 don't have that memorized, although I think you can 14 infer that by looking at the blank cells that appear 15 in the tables and thus it wasn't possible for those 16 third-party payers to compute a difference. 17 And I think that's -- in the documents I 18 produced along with my report, that question can be 19 answered. I just don't have it memorized. If we 20 went through and counted all of the blank cells that 21 appear, there wouldn't be the basis for making the 22 comparison because they didn't reimburse for both 23 omeprazole and Nexium in that particular month. 24 Q. Okay. And just to clarify, when you say 25 that those third-party payers were removed from the</p>
<p style="text-align: right;">Page 160</p> <p>1 tables, you don't mean that they were removed from 2 the figure; you just mean that that particular month 3 was blank? 4 A. Yeah. But if it turns out that there were 5 no months for that third-party payer, then that 6 third -- nothing would appear with regard to that 7 third-party payer because it wouldn't be possible to 8 compute a difference for any month. 9 Q. Your Figures 8 and 9 on page 24 list nine 10 30 party -- excuse me -- list nine third-party 11 payers; is that correct? 12 A. For California, yes. 13 Q. And then -- 14 A. That's only for California, remember. 15 Q. Oh, okay. 16 A. I presume you've read the report. We're 17 now talking just about California. Later I give you 18 the third-party payers for Massachusetts, on 19 pages 27, 28, 29. 20 Q. Okay. And that also includes nine, but 21 they're not all the same; hence adding up to the 14 22 payers that you have? 23 A. There you go. We got it. 24 Q. Always good to make everything make sense. 25 A. You should tell Mr. Weinstein the same</p>	<p style="text-align: right;">Page 161</p> <p>1 thing. 2 Q. Did you ever calculate a margin of error 3 or a confidence interval for the data that you 4 collected and the analysis you produced? 5 A. I certainly looked at that with regard to 6 the distribution. I reported here the median 7 differences. Is that your point? 8 Did I look at the entire distribution 9 around that median? Obviously, half the 10 distribution is above and half is below. Otherwise, 11 it wouldn't be a median. I also computed the mean. 12 I looked at the distribution itself, found that it 13 was basically symmetric. As I say, there's not much 14 difference at all between the mean and the median. 15 And with regard to your question: Did I 16 compute a confidence interval? No. But could a 17 confidence interval be computed? Yes. And would 18 the difference here with regard to after taking into 19 account DACON, manufacturer rebates and co-pays, 20 would it be significant as a difference? Yes. 21 But did I do that and report an actual 22 computed confidence interval? No. 23 Q. In reviewing the tables that you have 24 starting on page 24, so Figures 8, 9, 10, 11, 12, 25 13, 14 and 15, those are the tables that -- that</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 162..165

Page 162

1 cover the comparisons you drew in California and
2 Massachusetts; is that correct?
3 A. Yes.
4 Q. Just to get back -- sorry -- to the point
5 we made before about the confidence interval, have
6 you determined what confidence interval would show
7 that price difference is significant?
8 A. I didn't compute the confidence interval.
9 I just told you that.
10 Q. Do you have --
11 A. I mean, I looked --
12 Q. -- as an expert --
13 A. I looked at the actual distributions, and
14 the distributions, as I indicated, were symmetric.
15 Not in all cases, but pretty close. And given the
16 size of the sample, if I had formally tested, I
17 would have found they were statistically significant
18 at a sufficient level of confidence.
19 Q. Getting back to the figures -- sorry --
20 I've just listed -- and I realize I interrupted
21 that -- but the figures running from page 24 through
22 29.
23 A. 24. I'm sorry. Is there a question?
24 Q. Oh, I'm sorry. I just wanted you to take
25 a look at them.

Page 164

1 significance, I'm not looking at it specifically
2 with regard to any third-party payer but across all
3 third-party payers. And my analysis and the purpose
4 for my analysis is to look at it for all third-party
5 payers.
6 My assignment and the question that I'm
7 analyzing doesn't require me to look at it for a
8 specific third-party payer.
9 So am I concerned? Would I have preferred
10 to have all the cells filled? Certainly I would
11 have, but that's not what the data shows.
12 Q. Is there -- do you know whether you don't
13 have the data because there was a problem in the
14 underlying data, or if it was just that this
15 third-party payer simply did not cover anyone who
16 was purchasing one of the products or both of the
17 products in that month?
18 A. You're asking me for the underlying
19 explanation for why a cell doesn't -- or a
20 particular month for a particular third-party payer
21 doesn't allow a comparison.
22 No, I didn't go back and try to unravel
23 why there was no comparison. I simply looked at the
24 data and what the data says.
25 There was no reason, given I was concerned

Page 163

1 A. Okay.
2 Q. There are -- I believe we've previously
3 discussed that you would leave a cell blank when
4 there was no pharmacy log data for both Nexium and
5 generic omeprazole.
6 A. For that third-party payer in that month.
7 Q. Right.
8 A. Right.
9 Q. And so that's why there'd be a blank cell?
10 A. Yes.
11 Q. There are several third-party payers here,
12 notably Prime Therapeutics in California --
13 A. Yes.
14 Q. -- and Walgreens Health Initiatives, also
15 in California --
16 A. Yes.
17 Q. -- UnitedHealthcare and First Health Group
18 in Massachusetts, as well as Anthem in
19 Massachusetts, that have many more blank cells than
20 numbers.
21 A. That is correct.
22 Q. Does that in any way concern you with
23 regard to their usefulness in this sample?
24 A. Their usefulness? I'm looking at the
25 overall. With regard to any statistical

Page 165

1 about the overall universe with regard to the
2 pharmacy logs and all third-party payers, to unravel
3 why, for example, Prime Therapeutics, in the case of
4 California for the month of December '02, didn't
5 actually provide reimbursements for both Nexium and
6 omeprazole. No, I didn't.
7 Q. Okay. Okay. If you could look at
8 page 19, Footnote 14.
9 A. Footnote 14, you said?
10 Q. Mm-hmm.
11 A. Yes.
12 Q. Okay.
13 A. I'm there.
14 Q. So this is your description of the
15 pharmacy log data and where it came from; is that
16 right? Or --
17 A. A partial description.
18 Q. Partial description?
19 A. The text itself provides a description as
20 well, but this provides some additional detail.
21 Q. Okay. In the third paragraph in this
22 footnote, it begins:
23 "There was a considerable amount of
24 irregularity in the raw pharmacy log data.
25 For certain transactions, key data was

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 166..169

<p>Page 166</p> <p>1 missing, and for others, the data was 2 obviously entered incorrectly, so these 3 transactions were eliminated from my 4 analysis. The pharmacies used different 5 conventions for naming third party payers, 6 so these names had to be standardized 7 through considerable effort. Data fields 8 were sometimes ambiguously labeled, and as 9 a result the calculation of third party 10 payments was achieved only after extensive 11 data analysis and multiple communications 12 with the pharmacies." 13 Is that correct? 14 A. That is correct. 15 Q. Do you have any concerns for the accuracy 16 of all this underlying data that you've used? 17 A. No. In all data, there are outliers; 18 there are measurement errors; there is incorrect 19 reporting. And I'm not surprised that this raw data 20 with regard to pharmacy logs suffers from the same 21 sort of anomalies. I took into account those 22 anomalies and eliminated those transactions. 23 The relevant question is: What percentage 24 of the transactions do these represent? And they're 25 a very small percentage. My recollection is</p>	<p>Page 167</p> <p>1 something in the neighborhood of 2 to 3 percent of 2 all transactions. 3 That's not surprising. Most statistical 4 methodologies that are out there for identifying 5 outliers would exclude that amount of transactions 6 for large data sets of this type. 7 Q. But you did not feel the need to go back 8 and determine whether there was underlying data 9 problems to explain why the 14 payers that you end 10 up looking at, why some of them had so few months 11 with relevant data? 12 A. They didn't have a comparison. They had 13 data, but there was no comparison. You can't do a 14 comparison unless you have observations for each of 15 the two drugs. 16 Now, they were -- for example, in many of 17 these cases where there are blank cells, they were 18 reimbursing for one, but not the other. So that 19 shouldn't surprise us. 20 And moreover, I would point out to you 21 that there was a lot of work done by going back to 22 the pharmacies and communicating directly with them 23 to resolve any anomalies that existed in the data. 24 And some of it, it could be resolved; and in other 25 cases, it couldn't.</p>
<p>Page 168</p> <p>1 Q. Looking at page 13 of your report, 2 paragraph 24. 3 A. Page 13? Yes. 4 Q. All right. You note that: 5 "Individualized discounts and rebates 6 are negotiated at many intersections of 7 this flow chart, which makes actual 8 pharmaceutical prices highly variable." 9 Is that correct? 10 A. Yes. 11 Q. And you do consider that pharmaceutical 12 prices are highly variable? 13 A. Yes. 14 Q. And do you agree with the Kaiser Family 15 Foundation study that you quote, where you say -- 16 I'm sorry -- where they say that ". . . substantial 17 variations in what different purchasers pay for the 18 same drug"? 19 There are substantial variations. I'm 20 sorry. It's the second sentence of the quote. 21 A. Thank you. Yes, I agree with that. Yes, 22 certainly. 23 Q. And we've already discussed your comment 24 on paragraph 41 of your report, saying that health 25 plans are often regional in nature; is that correct?</p>	<p>Page 169</p> <p>1 And you stand by that? 2 A. Health -- some health plans are regional 3 in nature, and some are not. Yes, I stand by that 4 as well. 5 Q. And taking into account that 6 pharmaceutical prices are highly variable, that some 7 health plans are regional, that you were only 8 depending on 20 third-party payers pulled from 30 9 pharmacies in two states, you're still comfortable 10 with your conclusion that if omeprazole was more 11 expensive than Nexium for many third-party payers in 12 November 2003, that would have helped shape 13 AstraZeneca's motivation in the negotiation? 14 A. Yes, indeed. Once again, it's the best 15 available information. And there's no question that 16 AstraZeneca was very aggressive with regard to their 17 rebating and attempting to move volume of Nexium 18 through the market. And they could only achieve 19 that by maintaining similar sorts of incentives for 20 third-party payers relative to the generics that 21 were out in the marketplace at that point in time. 22 And moreover, any other prices that are 23 available with regard to non-primary transaction 24 prices that are reported in this industry, the 25 average wholesale price, the WAC price, the fact</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 170..173

<p style="text-align: right;">Page 170</p> <p>1 that no MAC had been established, even though there 2 was references and expectations that there might be 3 a MAC established somewhere along the line, those 4 prices already show great similarity between the 5 generic omeprazole that existed, even though three 6 generics were out on the marketplace as of 7 November 2003 and they kept their prices very high 8 relative to the Nexium price. 9 And that's the gross price. When you take 10 into account the net prices, there's even more 11 incentive for moving Nexium volume. 12 So, yes, there's no question that these 13 results demonstrate that part of the success with 14 regard to the market penetration of Nexium was, in 15 fact, the incentives that Nexium offered to 16 third-party payers and that the generics kept their 17 prices very high. 18 MS. KINBURN: I think this would be a good 19 time to take a break. 20 THE VIDEOGRAPHER: We're now going off the 21 record, and the time is 3:27. 22 (Recess taken.) 23 THE VIDEOGRAPHER: We are now back on the 24 record, and the time is 3:32. 25</p>	<p style="text-align: right;">Page 171</p> <p>1 BY MS. KINBURN: 2 Q. Dr. Rausser, I believe you've mentioned 3 the topic of switching between various PPIs. 4 If you could take a look at page 13 of 5 your California declaration, which I believe is now 6 Exhibit 11. 7 A. Yes. 8 Q. And in this declaration, you note that -- 9 I'm sorry -- on paragraph 23, right after the 10 redaction, data from NDCHealth confirms, I guess the 11 previous testimony. 12 "It indicates that, in the average 13 month in 2003, 5.4 percent of Nexium 14 patients had just switched from another 15 PPI." 16 And then you say that: 17 "The percentages for other branded PPIs 18 are similar." 19 Is that correct? 20 A. Yes. 21 Q. And you say: 22 "Omeprazole's percentage (15.7 percent) 23 is higher, mostly because it had recently 24 launched." 25 Is that right?</p>
<p style="text-align: right;">Page 172</p> <p>1 A. Yes. 2 Q. And you say that: 3 "The switching is fairly evenly 4 distributed among different PPIs." 5 A. Yes. 6 Q. And then you have a footnote, Footnote 12. 7 And in that footnote, you compare the number -- the 8 patients who switched to Nexium from another PPI to 9 the patients who switched away from Nexium to 10 another PPI. Is that correct? 11 A. Bear with me one second. It's been some 12 time since I read this. 13 Yes, that is correct. 14 Q. And if you look at the number of patients 15 who switched to Nexium from another PPI, the data -- 16 A. To Nexium, the first -- 17 Q. Yes. 18 A. -- category? 19 Q. To Nexium. 20 A. Yes. 21 Q. The percentage of patients who switch -- 22 excuse me -- switched to Nix- -- switched to Nexium 23 from another PPI where that other PPI is omeprazole 24 was 16.2 percent -- 25 A. Yes.</p>	<p style="text-align: right;">Page 173</p> <p>1 Q. -- of the patients that were coming to 2 Nexium? 3 A. Yes. 4 Q. And, in fact, most or, I guess, the 5 largest share of patients coming to Nexium came from 6 Prevacid. Is that correct? 7 A. Yes. 8 Q. And that was 34.8 percent of the new 9 patients that were switching over -- 10 A. Yes. 11 Q. -- came from Prevacid? 12 And then you also, in the next sentence, 13 go on to determine the percentages of patients who 14 switched away from Nexium to another PPI. And in 15 that, you find that 19 percent or 19.1 percent of 16 patients switching away from Nexium to another PPI 17 switched to generic omeprazole; is that correct? 18 A. That is correct. 19 Q. 25.7 percent of that population, that 20 patient population switched to Protonix; is that 21 correct? 22 A. Yes. 23 Q. And 32.4 percent to Prevacid? 24 A. Yes. 25 Q. I believe we discussed earlier in this</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 174..177

<p style="text-align: right;">Page 174</p> <p>1 deposition the fact that Nexium sold itself largely 2 on its efficacy. That was its marketing drive, was 3 that it was the best product. 4 A. I don't -- going back to their actual 5 marketing material, my recollection is they compared 6 their efficacy relative to Prilosec. 7 And in terms of the education of the 8 market, whether it is informative advertising and 9 promotion or persuasive advertising and promotion, 10 previously they had represented that Prilosec was 11 superior to other PPIs. So given fundamental logic, 12 if Prilosec was superior to the other PPIs at the 13 time and then Nexium comes along and is superior to 14 Prilosec, you can infer that what they were hoping 15 the market would believe is that Nexium was superior 16 to all other PPIs. 17 Now, there are a lot of P&T committees and 18 there are lots of arguments that no, Nexium was 19 nothing more than Prilosec. 20 Q. Okay. And I believe you've also discussed 21 the fact that third-party payers would look at the 22 cost-efficacy balance. 23 A. Yes. 24 Q. And did you understand that AstraZeneca 25 was positioning Nexium on that cost-efficacy balance</p>	<p style="text-align: right;">Page 175</p> <p>1 as -- this is going to be a figure of speech -- as 2 standing heavier on the efficacy as opposed to the 3 cost in comparison to the other available PPIs? 4 A. No, I don't think you can infer that. If 5 you look at what kind of rebates they were offering 6 to some of the managed care third-party payers, they 7 were focusing on cost more than they were on 8 efficacy. I mean, but it depends on who the -- who 9 the third-party payer or managed care facility they 10 are negotiating with, but I don't think you can 11 represent that in all instances they were weighting 12 their marketing effort just on efficacy. That's not 13 true. It was also weighted on cost. There's no 14 question about it. 15 Given their rebating structure and if you 16 look at their financial statements, they were 17 offering more in the way of incentives for discounts 18 against gross prices than I think any other 19 manufacturing branded pharmaceutical company out 20 there. Any one of the majors. Not any one, but the 21 majors. 22 I've certainly looked at the data with 23 regard to all the majors; Novartis, for example, or 24 Pfizer. And it turns out if you look across the 25 entire portfolio, much of which is driven by Nexium,</p>
<p style="text-align: right;">Page 176</p> <p>1 given how important it is for AstraZeneca, they were 2 offering the largest discounts to the marketplace. 3 Q. The largest discounts from the WAC, but 4 not the lowest WAC? 5 A. I would have to go back and look at 6 whether they had the lowest WAC or not. But I'm not 7 talking about WAC. I'm talking about the gross -- 8 whatever the gross price was that is reported by 9 AstraZeneca or IMS. 10 Against that gross price, they were 11 offering the largest deductions against that price, 12 whether the deductions are reflected in rebates or 13 chargebacks or returned product or free samples, 14 whatever. 15 Q. But the final cost has to reflect both the 16 gross price and also the rebate. So if Nexium 17 offered the biggest rebate but was twice as 18 expensive before the rebate, you need to consider 19 both of those factors in determining its relative 20 cost? 21 A. That's why, if you look in my report, when 22 I give you the five factors, I start with what is 23 the reimbursable value of the transaction. 24 Q. Okay. Can you take a look at what was 25 marked as Exhibit 5, which is the Graham deposition</p>	<p style="text-align: right;">Page 177</p> <p>1 transcript from May 31st, and take a look at 2 page 147 -- 3 A. Exhibit 5? 4 Q. -- to 148. 5 A. I'm sorry. What is Exhibit -- 6 Q. It may be to your -- 7 A. Left? 8 Q. -- to your left. 9 A. Oh. Thank you. 10 Q. On pages 147 to 148. 11 A. 147 to 148. 12 Q. No, I'm sorry. Just 148. 13 A. Just 148. 14 Q. It's in the lower right-hand corner. 15 All right. Do you see where -- it's the 16 first full paragraph on 148. Graham says: 17 "As we discussed earlier, Protonix and 18 Prevacid had a lot of low cost, cost 19 sensitive customers that Nexium didn't 20 have." 21 A. This is at the top of page 48? Oh, the 22 second paragraph. I see. 23 Q. Yes. 24 A. I see. 25 Yes.</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 202..205

<p style="text-align: right;">Page 202</p> <p>1 We're now going off the record, and the 2 time is 4:23. 3 (Recess taken.) 4 THE VIDEOGRAPHER: This marks the 5 beginning of Tape No. 4 in the video deposition of 6 Gordon Rausser. We are back on the record at 4:33. 7 BY MS. KINBURN: 8 Q. So looking at page 3 of Exhibit 18 -- 9 A. Yes. 10 Q. -- do you see in the second bullet point 11 that it says "Nexium lost an estimated 3 percent of 12 its volume to Prilosec OTC"? 13 A. Yes. 14 Q. Do you disagree with that finding? 15 A. Not based on the data that they're looking 16 at. They've got household data, and it's a fairly 17 large number of households. I haven't done an 18 analysis, nor do they in this report do an analysis 19 about the reliability of any inferences for the 20 entire marketplace. 21 MS. KINBURN: Okay. And then I'd like to 22 mark this as Exhibit 19. 23 (Whereupon, Deposition Exhibit 19 was 24 marked for identification.) 25 MS. KINBURN: For the record, this is AZD</p>	<p style="text-align: right;">Page 203</p> <p>1 166463. 2 BY MS. KINBURN: 3 Q. And once again, you can review this at 4 your leisure. I would like to direct your 5 attention, though, to pages 12 -- page 12 of the 6 report, which is 474. 7 A. Fourth quarter 2004. 8 Okay. Your question? 9 Q. So looking at page 12 -- 10 A. 12. 11 Q. Oh, and just for the record, this is a 12 Nexium fourth quarter 2004 performance review dated 13 January 11th, 2005, and it was an AstraZeneca 14 document, created by them. 15 A. Yes. 16 Q. All right. So if you look at the title -- 17 sorry -- of the slide that you see, it says: 18 "POTC" -- 19 Which I would assume is Prilosec OTC. 20 A. Yes. 21 Q. -- "Impacted Nexium EU volume by about 22 4 percent since September '03." 23 Do you see that? 24 A. I do. 25 Q. And do you see the graph below that title?</p>
<p style="text-align: right;">Page 204</p> <p>1 A. I do. 2 Q. And if you look at the second paragraph, 3 last sentence of that paragraph below this slide, 4 he's -- the person writing the report says: 5 "Using this methodology, I estimate 6 that POTC has slowed Nexium EU volume by 7 about 4 percent." 8 Do you see that? 9 A. I do. 10 Q. Okay. And do you have reason to disagree 11 with this analysis? 12 A. Yes. I completely disagree with this 13 analysis. 14 Q. Okay. And why would that be? 15 A. For a number of reasons. First of all, 16 they're attributing all of the change in the trend 17 to POTC, and they've done no analysis to separate 18 other possible causal influences. That's number 19 one. 20 Number two, the 4 percent is off a linear 21 line that they've drawn through the data points. 22 Now, first of all, I don't think that is an actual 23 minimize -- minimization of the error of sums of 24 squares. 25 Number three, you'll look at the actual</p>	<p style="text-align: right;">Page 205</p> <p>1 Nexium; it continues to rise over the period that 2 they infer that there's a 4 percent cumulative 3 impact. That cumulative impact is against the 4 linear line. But if you look at the actual rate of 5 growth over the period that's reported here, 6 namely -- what is it? -- September '03 through 7 November of '04, in the year '04 there is an 8 increase in the number of extended units. 9 They have done no analysis to be able to 10 demonstrate that this is all attributed to 11 Prilosec OTC. And I disagree with it completely. 12 This would never pass peer review standards. 13 Q. Turning back to your report, paragraph 11. 14 A. Yes. 15 Q. In about the middle of the paragraph, you 16 say in a parenthetical: 17 "These buyers' influence over the 18 choice of drug used is described in 19 greater detail in the declaration 20 submitted in this case by Robert 21 P. Navarro, Pharm.D." 22 Do you see that? 23 A. Mm-hmm, yes. 24 Q. And do you rely on that report to 25 establish any of the -- or to base any of the</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 206..209

Page 206

1 conclusions in your report?
2 A. No. I'm simply giving a source where you
3 can find a discussion of third-party payers'
4 influence and/or control over the volume being moved
5 through the market.

6 It's also based on the 40 to 60 or so
7 drugs and markets that I have analyzed over the
8 years, including all of the branded pharmaceutical
9 data that I had direct access to in the branded --
10 Brand Name Antitrust Litigation.

11 Q. Okay. So if Navarro's opinion was
12 excluded, that would have no effect on your
13 opinions?

14 A. That's correct.

15 Q. Looking at the next paragraph of your
16 report -- actually, no. Staying with the last
17 sentence of paragraph 11, so it's on page 6, you
18 comment that:

19 "Loss of this advantage" -- this
20 advantage being Nexium's lower cost to
21 third-party payers -- "could have
22 threatened Nexium's favorable formulary
23 status and its market share."

24 Is that correct?

25 A. Yes, that is correct.

Page 208

1 regard to maintaining and keeping at a relatively
2 high level the generic pricing that existed up to
3 November of '03, how close the actual pricing was of
4 the other generic forms of Prilosec, omeprazole that
5 were out in the marketplace.

6 And this goes to the data that is
7 described in Figure 3 and Figure 4 of my report and
8 the host of documents that were produced by
9 AstraZeneca, the deposition testimony of Mr. Graham
10 that you asked me about earlier, the actual
11 deposition that I referred to with regard to
12 Mr. Uhlich with regard to the so-called -- Uhle,
13 Uhle -- the so-called halo effect.

14 Q. Just taking a look through your report, it
15 appears that starting on page 9 --

16 A. Page 9?

17 Q. -- under the heading "The Price of a PPI"
18 through the rest of the text of your report
19 concentrates solely on establishing how to
20 establish -- establishing how to calculate a net
21 cost for a drug and then applying that calculation
22 to understand the net costs of Nexium and generic
23 omeprazole. Is that correct?

24 A. Yeah. The real price of therapy, that is
25 correct.

Page 207

1 Q. And then based on that, you move to
2 paragraph 12 and you state that:

3 "Knowing this at the time of the
4 hypothetical negotiation, AstraZeneca
5 would have had an economic interest in
6 maintaining omeprazole's higher cost to
7 third party payers relative to Nexium.
8 This would have created an incentive for
9 AstraZeneca to prevent the launch of an
10 additional generic version of omeprazole."
11 Do you see that?

12 A. I do.

13 Q. Okay. And so is the conclusion in
14 paragraph 12 about AstraZeneca's incentives based on
15 your opinion in paragraph 11 about the potential
16 loss of Nexium's cost advantage?

17 A. In part, yes.

18 Q. All right. Aside from your analysis of
19 Nexium's net cost, what else are you basing that
20 conclusion in paragraph 12 on?

21 A. All the work that I've done in the
22 pharmaceutical industry with regard to dynamic
23 interactions between the brand drug, a subsequent
24 drug that serves the same indications, the generic
25 competition, what happened in this marketplace with

Page 209

1 Q. So where in your report have you discussed
2 or established the rest of these bases for your
3 opinion that you just listed to me?

4 A. Well, first of all, some of the deposition
5 testimony that I referred to was not available. The
6 one was, but I didn't review that until after filing
7 my report.

8 My assignment, as I specified in my
9 report, was very narrow. It was just looking at the
10 relative costs and then analyzing, from an economic
11 perspective, what was the interest of AstraZeneca in
12 any hypothetical negotiation.

13 The deposition by Mr. Graham was not
14 available to me until after filing my initial
15 report. The opposing expert reports that have been
16 filed and the documents that they relied upon; I
17 went back and looked at all the documents that were
18 produced by AstraZeneca in the normal course of
19 their business, much of which I was already familiar
20 with because of my prior work in the Nexium class
21 litigation; and moreover, the body of work that I've
22 done in the pharmaceutical industry over the last 22
23 years.

24 Q. So those were all the things which you
25 would now rely on in explaining your opinion, but

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 210..213

<p style="text-align: right;">Page 210</p> <p>1 they're not in your report itself, are they?</p> <p>2 A. Yeah, they're in my report.</p> <p>3 The minimal amount of information with</p> <p>4 regard to IMS is in my report. The data on the</p> <p>5 average wholesale price, the WAC is in my report.</p> <p>6 All of the pharmacy log data's in my report.</p> <p>7 And my expertise with regard to the</p> <p>8 pharmaceutical industry in terms of the summary of</p> <p>9 my opinions in paragraphs 11 and 12, I presume</p> <p>10 that's what this deposition is for, is to determine</p> <p>11 what my basis is for the conclusions that I've</p> <p>12 drawn. And your questions have pointed us in the</p> <p>13 direction of what that foundation is. I've provided</p> <p>14 it.</p> <p>15 Q. So based on your expertise in the</p> <p>16 pharmaceutical industry and your review of the</p> <p>17 market data for generic omeprazole, did you come to</p> <p>18 any conclusions as to the extent of and the likely</p> <p>19 trend of omeprazole -- strike that question.</p> <p>20 Started well and then it ended poorly.</p> <p>21 A. It did start well. I thought I knew where</p> <p>22 you were going, and then I got confused.</p> <p>23 Q. So did I.</p> <p>24 All right. So relying on your expertise</p> <p>25 and your review of the data with regard to the</p>	<p style="text-align: right;">Page 211</p> <p>1 omeprazole market, the PPI market, are you able to</p> <p>2 tease out or to separate the effect of the generic</p> <p>3 entrants and the entrants of Prilosec OTC before</p> <p>4 Apotex and determine what effect -- what . . .</p> <p>5 A. What effect it had on the interest of</p> <p>6 AstraZeneca with regard to Nexium?</p> <p>7 Q. What effect that would have on the price</p> <p>8 of generic omeprazole if Apotex had not launched.</p> <p>9 A. Oh. Can I see if I can restate the</p> <p>10 question?</p> <p>11 Q. Yes, please do.</p> <p>12 A. Okay. In other words, I've analyzed the</p> <p>13 data with regard to omeprazole and the three generic</p> <p>14 manufacturers that were out there up through</p> <p>15 November '03.</p> <p>16 Is your question then, did I analyze the</p> <p>17 counterfactual of what would happened to those</p> <p>18 prices going forward if Apotex hadn't entered?</p> <p>19 Q. Or based on your expertise, could you give</p> <p>20 me your opinion as to what would have happened?</p> <p>21 A. Well, up to that point in time, I can</p> <p>22 represent to you what happened up to that point in</p> <p>23 time. Namely, there was an equilibrium that had</p> <p>24 been forged that kept the generic pricing very high</p> <p>25 and very close to Nexium and, for many third-party</p>
<p style="text-align: right;">Page 212</p> <p>1 payers, a preferred cost incentive for Nexium</p> <p>2 relative to those generics.</p> <p>3 If your question is "Would that have</p> <p>4 equilibrium continued in the counterfactual world in</p> <p>5 which Apotex hadn't entered the market?" all the</p> <p>6 evidence I've seen is that they had reached an</p> <p>7 equilibrium. That equilibrium was going to be</p> <p>8 disturbed by a generic entrant. Would it be exactly</p> <p>9 the same as it was in 2003? No, because there are</p> <p>10 other generics that subsequently took -- entered the</p> <p>11 market. There were other OTC products. Prevacid,</p> <p>12 for example, for an illustrative purpose, has an OTC</p> <p>13 product. So those would all have some effect on the</p> <p>14 market dynamics down the road.</p> <p>15 I haven't formally analyzed that</p> <p>16 counterfactual, but I can represent that coming into</p> <p>17 November of '03, that there was, in fact, a</p> <p>18 stationary equilibrium that had emerged and,</p> <p>19 moreover, that stationary equilibrium had benefited</p> <p>20 Nexium. And Nexium was capturing a lot of value in</p> <p>21 the marketplace at that point in time.</p> <p>22 And I would expect, and now I'm not</p> <p>23 talking about the counterfactual world but the</p> <p>24 actual world, with regard to another generic coming</p> <p>25 in, and the other generic could only achieve success</p>	<p style="text-align: right;">Page 213</p> <p>1 by price competition, only by price competition.</p> <p>2 And as a result, that would disturb the prior</p> <p>3 equilibrium and result in a less favorable position</p> <p>4 with regard to Nexium in the marketplace.</p> <p>5 Q. Okay. Were you aware of the production</p> <p>6 constraints on generic omeprazole in the first eight</p> <p>7 or nine months of 2003?</p> <p>8 A. Yes. There's reference in the discovery</p> <p>9 record to the first generic entrant facing capacity</p> <p>10 constraints, yes. And that would have had quite --</p> <p>11 as you would expect, would have had an effect on the</p> <p>12 penetration of that generic with regard to, one,</p> <p>13 pursuing more aggressive pricing strategies; and</p> <p>14 two, also being able to convert Prilosec, now,</p> <p>15 through a number of different mechanisms, one of</p> <p>16 which is very important is the automatic</p> <p>17 substitution.</p> <p>18 But if it turns out that prescriptions</p> <p>19 that were previously written for Prilosec are now</p> <p>20 written for Nexium, that automatic substitution</p> <p>21 wouldn't work anyway.</p> <p>22 Q. Okay. So given the supply constraints,</p> <p>23 could that have created this equilibrium that you</p> <p>24 noticed before Apotex's entry?</p> <p>25 A. Yes. But that equilibrium, at least with</p>

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Pages 218..220

Page 218	Page 219																																																																																								
<p>1 CHANGES AND SIGNATURE</p> <p>2</p> <p>3 WITNESS: GORDON C. RAUSSER, Ph.D.</p> <p>4 DEPO DATE: 8/9/13</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">PAGE</th> <th style="width: 10%;">LINE</th> <th style="width: 40%;">CHANGE</th> <th style="width: 40%;">REASON</th> </tr> </thead> <tbody> <tr><td>5</td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td></tr> <tr><td>7</td><td></td><td></td><td></td></tr> <tr><td>8</td><td></td><td></td><td></td></tr> <tr><td>9</td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td></td></tr> <tr><td>14</td><td></td><td></td><td></td></tr> <tr><td>15</td><td></td><td></td><td></td></tr> <tr><td>16</td><td></td><td></td><td></td></tr> <tr><td>17</td><td></td><td></td><td></td></tr> <tr><td>18</td><td></td><td></td><td></td></tr> <tr><td>19</td><td></td><td></td><td></td></tr> <tr><td>20</td><td></td><td></td><td></td></tr> <tr><td>21</td><td></td><td></td><td></td></tr> <tr><td>22</td><td></td><td></td><td></td></tr> <tr><td>23</td><td></td><td></td><td></td></tr> <tr><td>24</td><td></td><td></td><td></td></tr> <tr><td>25</td><td></td><td></td><td></td></tr> </tbody> </table>	PAGE	LINE	CHANGE	REASON	5				6				7				8				9				10				11				12				13				14				15				16				17				18				19				20				21				22				23				24				25				<p>1 I, GORDON C. RAUSSER, Ph.D., have read the</p> <p>2 foregoing deposition and hereby affix my signature</p> <p>3 that same is true and correct, except as noted</p> <p>4 above.</p> <p>5</p> <p>6 _____</p> <p>7 GORDON C. RAUSSER, Ph.D.</p> <p>8</p> <p>9 THE STATE OF _____)</p> <p>10 COUNTY OF _____)</p> <p>11</p> <p>12 Before me, _____,</p> <p>13 on this day personally appeared GORDON C. RAUSSER,</p> <p>14 Ph.D., known to me (or proved to me under oath or</p> <p>15 through _____) (description of identity</p> <p>16 card or other document) to be the person whose name</p> <p>17 is subscribed to the foregoing instrument and</p> <p>18 acknowledged to me that they executed the same for</p> <p>19 the purposes and consideration therein expressed.</p> <p>20 Given under my hand and seal of office</p> <p>21 this _____ day of _____,</p> <p>22 20 ____.</p> <p>23</p> <p>24 _____</p> <p>25 Notary Public in and for</p> <p>the State of _____</p> <p>Commission Expires: _____</p>
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<p style="text-align: right;">Page 220</p> <p>1 CERTIFICATE OF REPORTER</p> <p>2 I, the undersigned, a Certified Shorthand</p> <p>3 Reporter of the State of California, do hereby</p> <p>4 certify:</p> <p>5 That the foregoing proceedings were taken</p> <p>6 before me at the time and place herein set forth;</p> <p>7 that any witnesses in the foregoing proceedings,</p> <p>8 prior to testifying, were placed under oath; that a</p> <p>9 verbatim record of the proceedings was made by me</p> <p>10 using machine shorthand which was thereafter</p> <p>11 transcribed under my direction; further, that the</p> <p>12 foregoing is an accurate transcription thereof.</p> <p>13 Further, that if the foregoing pertains to</p> <p>14 the original transcript of a deposition in a Federal</p> <p>15 Case, before completion of the proceedings, review</p> <p>16 of the transcript [X] was [] was not requested.</p> <p>17 I further certify that I am neither</p> <p>18 financially interested in the action nor a relative</p> <p>19 or employee of any attorney or any of the parties.</p> <p>20 IN WITNESS WHEREOF, I have this date</p> <p>21 subscribed my name.</p> <p>22 Dated: 8/18/2013 <u>Ana M. Dub</u></p> <p>23</p> <p>24 ANA M. DUB, CSR No. 7445</p> <p>25 RPR, RMR, CRR, CCRR, CLR</p>																																																																																									

DEPOSITION ERRATA SHEET

Case: *AstraZeneca AB v. Apotex*, Case No. 01-CIV-9351
Witness: Gordon C. Rausser, Ph.D.
Depo Date: August 9, 2013

Page	Line	Correction
10	5	Change "Sidley & Austin" to "Sidley Austin"
10	15	Change "Sidley & Austin" to "Sidley Austin"
12	9	Change "Donna" to "Dawna"
22	12-13	Change "the role of formularies, and the Takeda." to "the role of formularies, and the Takeda publication."
41	15	Change "sparse" to "parse"
49	18	Change "a specific managed care?" to "a specific managed care organization?"
58	8	Change "PPM" to "PBM"
75	2	Change "Yes" to "No, I said well below 20%"
77	1	Change "or was it available" to "nor was it available"
83	24	Change "from Nexium and Prilosec" to "between Nexium and Prilosec"
84	14	Change "PT" to "P&T"
91	6	Change "samples doesn't" to "samples adjustment doesn't"
92	21	Change "care operate" to "care organizations operate"
93	8	Change "pre-authorization" to "prior authorization"
94	12	Change "Metamedia" to "MediMedia"
133	13	Change "rebates versus the co-pays versus the DAConS" to "rebates versus the DAConS versus the free samples"
133	18-19	Delete "I then make the correction for the co-pay;"
151	22	Change "other" to "others"

156	9	Change “managed care for” to “managed care organizations for”
160	4	Change “Yeah. But if it turns out” to “If it turns out”
185	13	Change “October” to “December”
192	6	Delete “No”
192	17	Change “that they are still” to “that there are still”
197	25	Change “Nexium swamp” to “Nexium sales swamp”
198	21	Change “there is generic entrants” to “there are generic entrants”
205	1	Change “Nexium; it continues” to “Nexium units; they continue”
211	17	Change “what would happened” to “ what would have happened”
212	3-4	Change ““Would that have equilibrium” to ““Would that equilibrium have”

ASTRAZENECA AB vs. APOTEX
Gordon Rausser Confidential

Job 15216
Page 219

I, GORDON C. RAUSSER, Ph.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

GORDON C. RAUSSER, Ph.D.

THE STATE OF _____)
COUNTY OF _____)

Before me, _____,
on this day personally appeared GORDON C. RAUSSER,
Ph.D., known to me (or proved to me under oath or
through _____) (description of identity
card or other document) to be the person whose name
is subscribed to the foregoing instrument and
acknowledged to me that they executed the same for
the purposes and consideration therein expressed.

Given under my hand and seal of office
this _____ day of _____,
20 ____.

Notary Public in and for
the State of _____
Commission Expires: _____

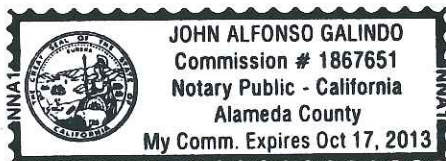
See attached Certificate.

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California

County of AlamedaOn 9/19/2013
Date

before me,

John Galindo, Notary Public
Here Insert Name and Title of the Officerpersonally appeared Gordon Rousser
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: John Galindo

Signature of Notary Public

Place Notary Seal and/or Stamp Above

OPTIONAL

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Signer's Name: _____

☐ Corporate Officer — Title(s): _____☐ Corporate Officer — Title(s): _____☐ Individual☐ Individual☐ Partner — ☐ Limited ☐ General☐ Partner — ☐ Limited ☐ General☐ Attorney in Fact☐ Attorney in Fact☐ Trustee☐ Trustee☐ Guardian or Conservator☐ Guardian or Conservator☐ Other: _____☐ Other: _____

Signer Is Representing: _____

Signer Is Representing: _____

RIGHT THUMBPRINT
OF SIGNER
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